

CRIME AND INSANITY

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BY

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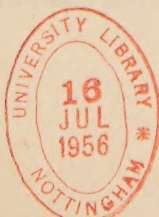
MEDICAL SUPERINTENDENT, BROADMOOR CRIMINAL
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To
SIR FREDERICK WALKER MOTT,
K.B.E., F.R.S., M.D., F.R.C.P.

AS A TRIBUTE OF ADMIRATION TO THE SCIENTIST
AND OF FRIENDSHIP TO THE MAN

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PREFACE

This book is an expansion of the matter of a series of lectures on "Crime and Insanity" which I have delivered during the last three years, as part of the course of post-graduate instruction in Psychiatry, organized by Sir Frederick Mott at the Maudsley Hospital, Denmark Hill. In the preparation and delivery of these lectures I have repeatedly had occasion to feel the serious inconvenience arising from the lack of any satisfactory text-book, dealing specifically with the subject of morbid crime, to which students could be referred for a fuller and more detailed discussion of the matters treated in the classroom. Disorders of conduct are, no doubt, dealt with in the ordinary treatises on mental disease, but only incidentally, and not in the connected and systematic manner which the importance of this social aspect of insanity demands. There are also, of course, numerous works on the criminal responsibility of the insane, but these, again, approach the subject from the special and limited point of view determined by the artificial standards of the law, and are for the most part concerned more with metaphysical speculations or with the discussion of legal subtleties than with the examination of clinical facts. It has seemed to me, therefore, that a useful purpose might be served by a study of morbid crime on a somewhat different plan, at once more narrow and more comprehensive—more narrow in its psychiatric scope, in laying stress mainly on the conduct symptoms of mental

disease, and more comprehensive, in considering these symptoms, not merely in their relation to criminal responsibility, but also and more insistently, in themselves, in their nature and origin.

That is the plan on which this volume has been written. It is designed primarily in the hope that it may be of use to students of psychiatry, and to medical men and lawyers whose professional work brings them in contact with problems of crime and criminal responsibility. But, as the interest which attaches to these problems is by no means confined to such specialists, but is shared by a large and increasing section of the educated public, I have thought it desirable to treat the subject in a manner that may make the book suitable also to the general reader. That is why I have included explanatory statements regarding psychiatric facts and theories which would, of course, be superfluous in a work addressed solely to technical students.

In dealing with matters which touch so many fields of inquiry, and which, in their various aspects, have been the subject of so much discussion, it is difficult for a writer to make out a full and accurate account of his indebtedness; but I have endeavoured, in the bibliographic references in the foot-notes, to make due acknowledgement of my conscious borrowings in points of detail. A larger debt, which cannot be brought into any statement of specific items, I owe to the teachings of that master in morbid psychology—the late Dr. Henry Maudsley. It is a privilege of which I am deeply sensible that the origin of this work should be associated with an institution founded by the generosity and bearing the name of that great man.

W. C. S.

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CHAPTER I

INTRODUCTORY: CRIME AS A BIO-SOCIAL PROBLEM

The chief aim of this work is to consider, from the standpoint of clinical experience, the nature and extent of the influence of psychopathological conditions in the causation of those disorders of social conduct which come within the purview of the criminal law. In their immediate practical bearing, the facts to be discussed are mainly of importance in connection with the problem of the legal responsibility of persons of diseased or defective mentality who are accused of criminal offences: and this particular aspect of the question will be kept constantly in view in the following pages, and will be the object of special examination in the concluding section of the book. Responsibility, however, is an arbitrary and fluctuating conception, which cannot usefully be applied to delimiting a category of facts of conduct; and a study of morbid crime would obviously be very imperfect if it were to be rigidly confined to such anti-social acts as may happen to satisfy the conditions of any local and temporary standard established by legal practice. Our consideration of the subject, accordingly, will not be bounded by any such restriction, but will cover the whole field of morbid delinquency, irrespective in the first instance of whether the influence of the psychopathological elements involved is or is not sufficient to entail the legal irresponsibility of the delinquents. That is to say, the descrip-

tion and analysis of the clinical facts, to which the bulk of the volume will be devoted, will precede and furnish the material for the discussion of the special problem of criminal responsibility.

Further, as there is, of course, no sharp dividing line between crime which is predominantly due to psychopathological conditions in the criminal, and crime which by comparison may be regarded as normal, and as the extent and importance of morbid crime cannot be viewed with an adequate sense of proportion unless it is considered in relation to the whole volume of delinquency, it is clearly necessary to preface our inquiry by some account of the general data, and especially the statistical data, of criminality. A brief survey of the more important of these data, and a summary examination of some of the criminological theories founded upon them, will be the matter of the introductory chapters of the book.

Crime, considered comprehensively and without regard to the complex and heterogeneous nature of the disorders of conduct denoted by the word, is one of a group of social problems constituted by the occurrence on a large scale of modes of behaviour which conflict with the recognized standards of the community. In all these bio-social problems there is an interaction of two sets of factors—on the one hand, factors inherent in the individuals exhibiting the particular type of conduct in question, and, on the other hand, factors due to the influence of the environment, or, to put it more shortly in two terms whose convenience has brought them into general use, there are factors of nature and factors of nurture. Of course, the distinction between these two sets of factors is to some extent artificial. It is obvious that the proximate causes of conduct are always biological, and the action of the environment upon conduct is necessarily exercised through the biological modifica-

tions which it induces ; when adverse economic conditions impel to crime or to prostitution, it is because these modes of behaviour furnish the means of satisfying bodily needs. And on the other hand, it is equally obvious that organic predispositions innate in the individual may be ultimately attributable to the operation of environmental forces acting upon antecedent generations ; even the most extreme opponent of the theory of the transmission of acquired characters will hardly dispute the possibility that deleterious influences such as chronic intoxications, acting on the parental germ cells, may affect the development and consequently the nervous organization of the offspring ; and he will certainly admit that environment plays some part in determining mating, and must thereby have an influence on the combinations of characters in the individuals of the filial generation. The factors of nature and nurture are not, therefore, to be too rigidly isolated.

When, however, bio-social problems are considered from the more limited point of view of their relation to influences operative at any given moment in the life of a community, it is justifiable to separate in theory the action of the environment from the special tendencies of response which may be inherent in certain of the individuals exposed to this action : and such a separation is practically convenient as affording guidance for possible measures of prevention, whether directed to modifying unfavourable environmental conditions or to excluding from their influence the persons predisposed to obnoxious reactions.

The differentiation of the two sets of factors in question may obviously be a matter of very considerable difficulty even in individual instances, and still more when the phenomena are considered in the mass. But it is nevertheless possible, on a broad view of the facts, to recognize

that in some bio-social problems the factors of the individual constitutional order are of predominant importance, whereas in others they appear to be relatively insignificant in comparison with the influence of environmental forces. As an example of a problem in which original biological tendencies play the chief rôle, we may take insanity. It is true, no doubt, that in the causation of insanity some importance is ordinarily attributed to the action of various conditions of stress, but even those who rate the effect of such stresses most highly are careful to emphasize their inadequacy in the absence of special morbid predisposition. And it appears, in fact, quite clear that the frequency and distribution of mental disease, as measured by asylum statistics, show little if any trace of the influence of exogenous conditions. Even such perturbations of social life as are produced by devastating wars do not materially affect the rate of insanity, nor is it modified to any appreciable extent by the fluctuations of economic prosperity which react so potently on phenomena of a more predominantly social character. The practically equal incidence of mental disease on the two sexes, despite the larger share taken by men in social and industrial activities, may perhaps be regarded as a further evidence of the relative insignificance of the environmental factors of insanity. In a problem where the causal conditions are mainly of the sociological order, as, for example, in alcoholism, the position is entirely different. Alcoholism, in its distribution and in its fluctuations, shows a high degree of dependence on environmental influences.¹ Its rate of incidence varies widely from one industrial group to another, but exhibits a remarkable constancy in the same group over long periods of time. In correspondence with the disparity in the social and industrial

¹ W. C. Sullivan, *Alcoholism*, London, 1906.

activities of the sexes, it is far more frequent in men than in women. Its statistical movement is decidedly and immediately affected by changes in economic conditions. And further, as has been conclusively shown by the experience of war legislation, it can be controlled to a very great extent by acting on the environmental influences which foster its development.

There are, of course, numerous exceptions to these general propositions, both in the case of insanity and of alcoholism. In general paralysis of the insane, for instance, and in the small group of alcoholic insanities, the chief causal factors are exogenous, and their operation can be controlled by social action. And on the other hand, amongst the mass of alcoholics, there are some individuals, forming, however, only a very small fraction of the whole, in whom an original defect of nervous organization plays an important part in the development of the habit of excess. Such instances, however, do not affect the validity of the inference, drawn from a broad view of the evidence, that the predominant causal factors are constitutional in insanity, environmental in alcoholism.

Now if the same rough criteria are applied to the case of criminality, it will be found that this problem has much more resemblance to alcoholism than to insanity, as regards the relation between its biological and its social factors. Thus, like alcoholism though to a lesser degree, crime reacts promptly to changes in the economic conditions of the community. It is notorious that in years of prosperity, when trade is brisk, employment good, and wages are high, crime tends to decrease, while in years of economic depression it tends to rise.¹ Again in agreement with alcoholism and in contrast with

¹ W. A. Bonger, *Criminality and Economic Conditions* (American Ed.), Boston, 1916.

insanity, criminality has a much heavier incidence on men than on women. And, of course, the movement of crime can be influenced to a considerable extent by appropriate social action. The possibility, indeed, of controlling it by such action is assumed as the basis of all the preventive and penal measures which form an essential part of the institutions of every civilized state ; and though the results achieved by these measures have hardly come up to the too sanguine expectations of social reformers, no one would seriously suggest that they have not exercised a potent restraining influence on criminal activity. There are numerous instances of an increase of crime following upon a weakening of police control, and of an increase of alcoholism accompanying a relaxation of the liquor laws ; but there is no reason to suppose that an inadequate supply of alienists would have any corresponding effect on the aggregate amount of insanity.

As against the view here maintained, it can, no doubt, be argued that, while environmental conditions may play a large part in the causation of crime, and, by reason of their frequently mobile character, may exercise a considerable and immediately apparent influence on its statistical movement, nevertheless these social factors will only be effective when they are combined with biological factors of a specific character ; in other words, it may be said that the milieu does not really make the criminal, but merely selects from the community those of its members who are of innately criminal disposition. And, in one form or another, this doctrine has, in fact, been put forward very often in explanation of crime, just as an essentially similar theory has been used to explain other bio-social phenomena, such as alcoholism and prostitution. By deduction from the general principle involved in this argument, any sort of abnormal

social conduct is supposed to be fully accounted for by ascribing it to a corresponding innate tendency—a tendency which, if it is not absolutely confined to the persons displaying the particular type of conduct in question, is at all events of much greater original intensity in them than in their fellows.

On this fundamental assumption that criminality implies the existence in the criminal of a specific anti-social tendency, more elaborate criminological theories have been built up within the last half-century, of which that associated with the name of the Italian alienist, Cesare Lombroso, enjoyed for a time considerable repute. According to Lombroso,¹ the true criminal is a separate species of the race, characterized by an innate incapacity of adaptation to the conditions of social life, and marked off from normal man by a number of distinctive anatomical and physiological traits. So distinctive, indeed, were these traits considered to be that differences in their combination and in their degree of development were supposed to indicate even special forms of criminal disposition, so that it was held to be possible to establish definite biological groups of instinctive thieves, instinctive homicides and instinctive prostitutes. The views of the Italian criminologists as to the origin of this racial variety and as to its relation to normal man, were not very clearly defined. Sometimes the criminal was regarded as a throw-back to primitive man, who, for the purposes of the theory, was credited, on rather slender grounds, with all the most undesirable qualities conceivable in debased humanity. Sometimes, again, he was considered to be pathological rather than abnormal, and his presumed anti-social instincts were attributed to morbid conditions of various sorts, and most frequently

¹ C. Lombroso, *L'Uomo Delinquente*, Turin, 1896.

to epilepsy. By other authorities he was more vaguely described as a degenerate.

Lombroso claimed for his theory of the born delinquent that, in contrast with previously current doctrines regarding the nature of crime, it rested on a firm basis of ascertained fact; and though the data on which he relied were of very doubtful accuracy, it is just to recognize that he rendered a real service to criminology by emphasizing the importance of the direct study of the criminal personality as the fundamental method in the investigation of the biological factors of crime. His merits in this respect have been too frequently ignored in the reaction against the errors and extravagances of his doctrine.

The vogue of Lombroso's theory was short; it was speedily extinguished by the criticisms of the French anthropologist, Manouvrier,¹ who pointed out the essential fallacy of its assumption that criminals are a biological and not merely a sociological category. And, if further refutation had been needed, it was supplied by the elaborate researches in which Baer,² and, more recently, Goring,³ demonstrated that the anatomical and physiological characters of criminals do not differ from those of the law-abiding members of the community.

The biological theory of crime which ranks next to Lombroso's in influence and repute is that which connects criminal conduct with mental deficiency. It has been developed most fully in this country, and is based mainly on the results obtained by Dr. Goring from his analysis of mass statistics referring to convicts under

¹ Manouvrier, *Les Aptitudes et les Actes*, Paris, 1891; *La Genèse normale du Crime*, Paris, 1893.

² A. Baer, *Der Verbrecher in Anthropologischer Beziehung*, Leipzig, 1893.

³ C. Goring, *The English Convict*, London, 1913.

sentence in English prisons. The theory maintains that the high correlation between criminality and feebleness of mind, revealed by this analysis, is to be interpreted as showing that "the one vital mental constitutional factor in the etiology of crime is defective intelligence."¹ It must be presumed that this statement, if it purports to have any positive value, is meant to convey that some degree of defective intelligence is a necessary element in criminal conduct. And that is certainly the sense in which it is commonly taken by those who regard it as a constructive contribution to criminology. Feeble-mindedness, in fact, is supposed to play much the same sort of part in criminality that copper plays in brass, and just as the presence of some amount of copper is necessary to constitute brass, so the existence of some degree of mental defect is considered to be a necessary ingredient in a criminal. This may seem a somewhat distorted presentation of the theory, but it is difficult to see in what other way it can be understood, unless we are to assume that the proposition quoted above is nothing more than a re-statement, in cumbrous language, of the very familiar fact that the proportion of feeble-minded persons is relatively much higher in the prison population than in the free population. As such a re-statement would obviously be needless, and could only tend to confuse the discussion, it is more reasonable to suppose that the theory does mean to affirm that mental defect is an essential factor in criminality. If that interpretation be correct, then it would seem that the theory in its fundamental principles bears a very close resemblance to Lombroso's doctrine of the born criminal. Common to both theories is the assumption that phenomena of social conduct can be directly referred to conditions of organic constitution, that criminality is the result of a

¹ C. Goring, *op. cit.* (abridged edition, p. 184).

specific biological predisposition and is not to any appreciable extent a product of environmental forces : the only point of difference is that in the later theory mental deficiency fills the rôle which Lombroso assigned to atavism or epilepsy or degeneracy.

The capital error involved in this way of envisaging crime is its radical misconception of the nature of the facts with which it proposes to deal. Crime is not, as all such theories assume, the simple, uniform expression of a definite biological state : it is merely a comprehensive term to denote a heterogeneous collection of facts of conduct with no common element that can possibly be related to a specific constitutional condition. Generalizations about "crime" and "criminals" founded on the assumed existence of any such condition are thus bound to be illusory ; they proceed, as Manouvrier pointed out in his strictures on the doctrine of Lombroso, from a confusion between *aptitudes*, which are inherent in the organism, and *acts*, which utilize these aptitudes, but to the most diverse ends and under the influence of different and infinitely complex conditions in the individual and in his environment. A burglar is defined and characterized by his acts and not by his aptitudes, which, if he is a competent burglar, will probably be much the same as the aptitudes of a good mechanic ; these aptitudes are used in anti-social acts in one case, and in social acts in the other, but we have no ground for inferring from that fact alone, and without further evidence, that the burglar differs from the mechanic through any peculiarity of organization.

Thus, under whatever form it may be presented, the theory of a specific inborn tendency as the origin of criminal conduct is plainly unsound in its fundamental assumptions. And, so far as it can be tested by positive evidence it not only fails to give a plausible explanation

of the facts of criminality, but is found to be clearly inconsistent with them in points of importance. Take, for example, one of the most constant and best ascertained of the statistical data of crime, namely, the differences in its incidence according to age. It will be seen from Table I, which shows the age distribution of

TABLE I

PERSONS CONVICTED OF INDICTABLE OFFENCES.

Proportion per 100,000 of Population of same Age.
1893 and 1905.

<i>Age.</i>	1893.	1905.
Under 12	24	23
12-16	261	218
16-21	321	275
21-30	245	247
30-40	204	210
40-50	143	158
50-60	92	91
Over 60	56	53

(From *Judicial Statistics, England and Wales, 1905: Part I, Criminal Statistics.*)

persons convicted of indictable crimes in England and Wales, that the proportion of criminals to the general population of the same age rises rapidly to a maximum level between the ages of 16 and 21 years, and then falls steadily in each successive age-group. A similar predominance of criminality in the period of adolescence and early manhood is found in other European countries, and may be considered to be a regular characteristic of crime in contemporary civilizations.¹ How is it to be reconciled with the theory of innate criminal disposition? If crime results from an inborn anti-social tendency, either specific in kind or exceptional in degree, and if, as the advocates of this theory tell us, the tendency is

¹ Aschaffenburg, *Das Verbrechen und seine Bekämpfung*, Heidelberg, 1906.

strongest in those individuals in whom it is earliest manifest, then we should obviously expect a quite contrary result. Instead of decreasing, criminality should increase with age, by the addition from each successive age-group of new recruits to the army of constitutional and instinctive law-breakers. It is remarkable that the criminologists of the extreme biological school should have ignored this difficulty, for they have given close attention to other aspects of the relation of age to criminality which have appeared to them to give support to their special views. For example, they have laid much stress on the familiar fact that the majority of habitual offenders commence their anti-social career at an early age ; this fact they have interpreted as cogent evidence of the instinctive origin of criminality, and they have even used it to establish a parallel between crime and certain diseases, such as scarlet fever and measles, which are constitutional in the sense that they are contracted only by persons who are peculiarly liable to infection. As the predominance of innate predisposition in the victims of these diseases is shown by a curve of age incidence which attains its highest point in the first years of life, so, we are invited to believe, does the precocity of crime in habitual delinquents prove their inborn anti-social temperament—in both cases the constitutional tendency is revealed by the early occurrence of the characteristic reaction to environmental conditions. The disciples of the doctrine of innate criminality unfortunately stop short at this point : had they gone on to show that a first criminal offence, like an attack of scarlet fever, tends either to prevent recurrence or to cause death, they might have applied this remarkable argument from analogy to account for the fact, which would appear otherwise to be inexplicable on their theory, that crime decreases with age. As, however, it is notorious

that a criminal act does not by any means confer immunity from relapse and is not ordinarily fatal to the criminal, the facts set out in Table I remain hopelessly inconsistent with the theory that a specific constitutional predisposition in the criminal is the predominant factor in the causation of crime.

To point out the essential fallacies of the purely biological theories of crime is not, of course, to dispute the importance of constitutional factors in criminal as in all conduct ; it is merely to insist on the very obvious and commonplace truth that such conduct is the outcome of the interaction of biological and sociological factors, of organic disposition and of environment, and that these factors are far too numerous, too complex, too variable in different individuals, and in the same individual at different times, to be susceptible of analysis by methods of investigation applied to criminals in the mass. To some extent these considerations hold good of all problems of social conduct ; but they are of peculiar force in the case of crime, for the facts of conduct comprised under the heading of crime present a much greater diversity of character and origin. To appreciate this it is only necessary to consider for a moment the meaning of the word. As defined in legal text-books a crime is "an act or omission forbidden by the law under pain of punishment." Crime, that is to say, is created by the law. Laws are the formal expression of the will of the community, and acts or omissions which conflict with that will, as expressed in the penal code, are criminal. The criteria of criminal conduct are thus furnished by the law and by the law alone ; and the only common character which belongs to all the aberrations of social conduct which we call criminal is their illegality. It is obvious that the acts which are brought into a single category by reference to such a standard as this will be

very different in their nature and origin, and in the mode and degree of their dependence on the several conditions, constitutional and environmental, which may determine or influence social conduct. Thus, for example, to take only offences of admittedly grave character, theft, arson, burglary, fraud, rape, murder, are all crimes, but their biological and social factors may obviously be very different, and generalizations about them or about the persons who commit them must be subject to so many and so considerable qualifications as to leave them very little value. And the same considerations apply, though, no doubt, to a lesser degree, even in the case of particular forms of crime ; the imbecile who fires a hay-rick for the pleasure of seeing a blaze, and the fraudulent tradesman who burns down his premises for the sake of the insurance money, are both guilty of arson, but it is evident that, except in the material fact and in its legal aspect, there is nothing in common in the conduct of the two delinquents.

X Thus the practical conclusion to which we are led when we go behind the general terms of crime and criminal to the actual facts which these terms connote, is that the only reliable method of investigating the biological factors of criminal conduct must be the slow and tedious way of clinical observation ; it does not lead to the prompt and sweeping generalizations that can be so readily furnished by the applications of *a priori* principles to the interpretation of mass statistics, but the results which it yields, if more tentative and more modest in appearance, have the superiority of being more firmly founded in fact. Moreover, in their bearing on treatment, these results have a practical value which does not attach to the conclusions arrived at by other and more pretentious methods. Confronted with a case of larceny, we get no help in this respect from mathe-

mathematical formulæ showing the correlation of crimes of acquisitiveness with "general intelligence," or with this or that bodily or mental trait. But we get definite and useful guidance from the results of a thorough clinical examination of the individual offender; we ascertain, for instance, that he presents the characteristic symptoms of general paralysis and is a subject for treatment in an asylum, or that he is an imbecile whose proper place is in an institution for mental defectives, or again that he is an ordinary sort of person whose misconduct is mainly due to stress of circumstances and may be corrected by appropriate influences. It is from the accumulated results of many such individual observations—supplemented and controlled by the broad facts of criminal statistics, which find here their proper function—that we may hope eventually to build up theories of increasingly wider scope regarding the factors of criminal conduct.

At all events, whatever be the rôle of the clinical method in general criminology, there can be no question that it is the only sound method of investigating the relation of psychopathology to crime. Even if other methods possess all the virtues which their advocates attribute to them, it is evident that the validity of their results in regard to this special aspect of the problem must depend on the quality of the data to which they are applied; and these data can only be reliable in so far as they have been acquired by the full and accurate observation of individual instances of morbid crime.

CHAPTER II

PSYCHOLOGICAL CLASSIFICATION OF CRIMES

It was observed in the preceding chapter that the acts comprised under the heading of crimes are of such diverse character and are related to causal conditions so different and even opposed in their nature and mode of operation that generalizations referring to criminal conduct in the aggregate are peculiarly liable to fallacy, and at the best are of very limited significance. It is necessary to develop this point a little more fully before proceeding to the detailed examination of the psychopathological factors of crime, for, as we shall see in the course of the present chapter, the importance of these factors can only be duly appreciated when they are considered in their relation to the several varieties of criminality.

Since any act or omission forbidden and punishable by the law comes within the technical definition of a crime, it is obvious that crimes may vary within a very wide range in respect of their anti-social character. This fact is recognized in all penal codes by a division of offences according to the legal estimate of their gravity, as measured by the severity of the punishment they may entail. In English law crimes are distinguished on this principle as (i) indictable offences, i.e. those which admit of trial by jury, further subdivided into treasons, other felonies, and misdemeanours, and (ii) petty or non-indictable offences, which are tried summarily

by justices of the peace sitting without a jury. The French penal code divides offences into three categories of decreasing gravity, namely, *crimes*, *délits*, and *contraventions*. Most other European codes have either followed the French classification, or, as in the case of Italy, have adopted a simpler division into two grades, *delitti* and *contravvenzioni*. It is to be observed that the correspondence between the anti-social character and consequences of an act, and the severity of the punishment which may attach to it, is in many cases very imperfect. Thus, for instance, a breach of sanitary regulations, which may lead to a fatal epidemic, is evidently more serious for the community than a refusal on the part of a clergyman to use the book of Common Prayer, but the former offence is non-indictable, the latter indictable. On the whole, however, it may be safely assumed that indictable crime does represent in general opinion, which in this matter is the real measure of the anti-social quality of misconduct, the graver kind of criminality, and we shall, accordingly, in our consideration of crime, confine ourselves for the most part to indictable offences.

What we have next to do is to attempt a classification of these more serious forms of crime, and, from the point of view with which we are concerned, the basis of our classification must clearly be psychological. Of course, as has been already pointed out, in every form of criminal conduct the factors involved are variable and highly complex, and acts which superficially belong to the same category may differ altogether in their psychological nature and significance. Since our immediate purpose, however, is not to differentiate the phenomena of criminality into strictly homogeneous and well-defined groups as material on which to found assured conclusions, but is merely to obtain a general view of the problem in its

qualitative and quantitative aspects, we need not be deterred by this difficulty from accepting the facts at their face value, and classifying offences according to their apparent psychological character. In this way we can roughly distinguish in criminal conduct a few main types, each of which we may regard with reasonable probability as a manifestation of some one particular fundamental impulse.

Applying this principle to the offences recognized by English law as of seriously criminal character, we find that most of them can be brought under one or other of three headings—crimes of acquisitiveness, crimes of violence or homicidal crimes, and crimes of lust. The only important indictable offences not comprised within these categories are, crimes against the State, attempts to commit suicide, and malicious damage to property, including arson. Crimes against the State are infrequent in this country in normal times, and in many cases depend upon motives which place them in a quite different category from ordinary crime: we may accordingly leave them out of our consideration. The other two classes of crime, and especially suicidal attempts, are in many respects closely akin to crimes of violence, and may be grouped with them and with crimes of lust, as being commonly in more immediate relation to the impulses that prompt them—impulses, moreover, which, as we shall see later on, have considerable affinity with the impulses underlying homicidal crime.

The first question that arises when we examine the facts of criminality as classified on this rough psychological basis, is the relative frequency of the different types of crime which we have distinguished. The accompanying table (Table II), adapted from the Judicial Statistics issued annually by the Home Office, supplies the answer. It shows the distribution over the several groups defined

TABLE II

INDICTABLE OFFENCES (ENGLAND AND WALES).

Annual Averages (1910-1914) of Crimes reported to Police.

		<i>Percentage.</i>
Crimes of Acquisitiveness . . .	89,830	91·8
Crimes of Violence. . . .	1,987	2·0
Crimes against Morals . . .	2,345	2·4
Attempted Suicide	2,426	2·5
Arson and Malicious Damage . .	648	·6
Other Offences	688	·7
Total	97,924	100

above, of the indictable offences reported to the Police in England and Wales, the figures being the annual average number for the period 1910-14. This period has been selected in order to avoid the effect of any possible disturbing influences arising from the war; but in point of fact, the main features of the table would not be materially altered if it were based on the statistics of the last few years: it may be taken, therefore, as fairly representative of the ordinary state of criminality in this country.

It will be seen that the fact which emerges most clearly from this table is the enormous preponderance of crimes of acquisitiveness, which amount to over 90 per cent. of the whole volume of indictable crime. In comparison with crimes of acquisitiveness, the graver crimes of violence and of lust are numerically quite insignificant. And further analysis of the several groups would make this fact even more strikingly apparent: in this country for one murder (even including child murder) there are annually about 80 burglaries and about 450 larcenies; and rapes are only very little more frequent than murders.

It follows from the numerical predominance of acquisitive crime that the fluctuations in the frequency of this form of delinquency govern the general statistical move-

ment of criminality. It is important to bear this point in mind, for there is a common tendency to regard oscillations in the amount of crime as an index of the moral condition of the community ; and as people, when thinking or speaking of crime in the abstract, are apt to associate the term with the more dramatic offences, they not infrequently assume, consciously or unconsciously, that an increase of crime implies an increase of murder and rape, and a growth of general lawlessness. In reality, of course, it implies nothing of the sort ; an increase or decrease of crime as a whole may mean, and in fact almost always does mean nothing more than an increase or decrease of theft. So far, indeed, is it from meaning a corresponding rise or fall in the frequency of homicidal or sexual crime, that, if there is any simultaneous movement in these latter forms of delinquency, it is more likely to be in the opposite direction. The reason is that changes in economic conditions, which are the most mobile factors in the causation of crime, and have, therefore, most to do with its fluctuations, ordinarily affect crimes of acquisitiveness in a quite different way from homicidal and sexual crime. Thus, in periods of economic prosperity, thefts usually diminish, while rapes and indecent assaults, and, in a less degree, homicidal offences may tend somewhat to increase—generally, as we shall see in a later chapter, through the influence of alcoholic excess, which is, or, at all events, was before the war, more prevalent in good times.

The differences in psychological character and in numerical incidence between these several categories of criminal conduct are particularly important from the point of view of the relation of crime to psychopathological conditions. For that relation has a quite different value in crimes of violence and of lust from what it has in crimes of acquisitiveness. In the former categories of delin-

quency the morbid constitutional factors play a very large part, while in acquisitive crime their influence is comparatively insignificant. That does not mean, of course, that mental disease or abnormality is more likely to lead to homicidal or sexual offences than to acquisitive offences : on the contrary, it is probable that the insane, by reason of their insanity, commit theft much more often than they commit rape or murder. It merely means that, though insane thieves may be more numerous than insane murderers or insane perpetrators of rape, the proportion of cases of rape or murder due to insanity is very considerable, the proportion of thefts so small as to be almost negligible.

This conclusion can be asserted as a positive result of clinical experience ; but it may be worth while to point out that it also finds confirmation in the general statistics of criminality. For instance, if we compare these several categories of crime in respect to their seasonal frequency, we observe a very striking difference between them, which we may most reasonably explain as due to a relative predominance of the constitutional factors in crimes of violence and of lust. The accompanying table (III), based on the police returns of indictable offences, published in the Judicial Statistics for 1909, shows the distribution, over the several months of the year, of the three classes of crime which we are considering. It will be seen from this table, and from the chart which presents the figures in graphic form, that there is relatively little variation in the frequency of crimes of acquisitiveness from month to month : and further, that such difference in seasonal influence as does appear is shown in a tendency to increase in the winter. In crimes of violence and of lust, on the other hand, there is a very marked degree of seasonal fluctuation, giving a curve of incidence which rises to a maximum in June,

TABLE III

MONTHLY DISTRIBUTION OF MAIN VARIETIES OF CRIME.

	<i>Crimes of Acquisitiveness.</i>	<i>Crimes of Violence.</i>	<i>Crimes of Lust (exclusive of Bigamy).</i>
January	9.16	8.34	6.30
February	8.34	7.75	6.24
March	8.07	5.08	5.62
April	7.77	8.18	8.25
May	8.02	7.33	10.70
June	7.65	10.27	11.43
July	8.24	10.59	11.18
August	8.38	10.59	11.13
September	8.11	8.34	8.00
October	8.99	10.11	9.23
November	8.91	7.43	6.72
December	8.36	5.99	5.20



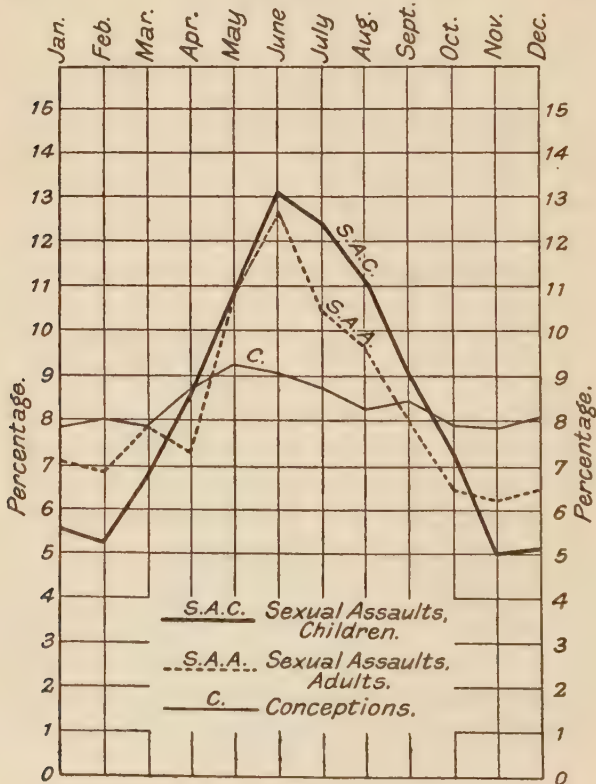
July, and August, and falls to a relatively low level during the colder months. If this greater prevalence of homicidal and sexual crime in summer is due, as it presumably is in the main, to a seasonal change in organic activity, we may regard it as evidence that in these forms of delinquency as compared with crimes of acquisitiveness, the biological factors play a much larger part. It is true, no doubt, that in the summer months there are also modifications of social life which may increase the opportunities for the perpetration of crimes of violence and, still more, of lust ; but we can hardly attribute very much importance to this indirect influence, in view of the fact that conduct phenomena which depend also on sexual impulse, but are not criminal in character, show the same seasonal reaction. Thus, as will be seen from Table IV and from the chart based on it, the curve of conceptions follows the same type as the curve of rape. The resemblance of these curves to one another, and to the curve of homicidal crime, points to the action of a common influence, which is presumably of organic origin. But there is an obvious likelihood that those forms of crime in which the biological factors are relatively important will be found more frequently to depend on morbid conditions in the criminal than will be the case with crimes which are predominantly due to influences of the sociological order ; and so we may consider these statistical data as confirmatory of the view that psychopathological elements play a large part in the causation of homicidal and sexual crime but are of very little account in the causation of crime of acquisitiveness.

Further evidence to the same effect may be found in the statistics of criminal lunacy. Thus, if we compare the number of insane criminals with the total number of offenders in each of the main categories of crime, we get the following results :—Of persons guilty of crimes of

TABLE IV

MONTHLY DISTRIBUTION OF SEXUAL ASSAULTS (1827-69) AND OF LEGITIMATE CONCEPTIONS (1863-71) IN FRANCE. (*Ferri, quoted by Aschaffenburg: "Das Verbrechen und seine Bekämpfung."*)

Month.	Sexual Assaults.		Conceptions.
	On Adults. Per cent.	On Children. Per cent.	
January	7.09	5.57	7.84
February	6.84	5.24	8.02
March	7.82	6.88	7.85
April	7.39	8.56	8.69
May	10.98	10.95	9.21
June	12.67	13.03	9.08
July	10.45	12.42	8.76
August	9.64	11.13	8.25
September	7.93	8.93	8.46
October	6.46	7.29	7.91
November	6.24	4.95	7.89
December	6.49	5.05	8.02



violence, on an average, one is found to be insane in every 27 ; in crimes of lust the proportion is one in every 160 ; in crimes of acquisitiveness, one in every 700. It should be remarked, however, that these statistics are not to be accepted without considerable reservation. In cases of homicidal crime there is ordinarily a much more careful scrutiny of the mental state of the accused person than in cases of less serious delinquency, so that the figures are likely to give a more reliable estimate of the influence of insanity on crimes of violence than of its influence on crimes of lust or of acquisitiveness. Further, homicidal charges generally go to trial, but in many cases of acquisitive crime the recognition of mental disorder in the accused leads to the abandonment of the prosecution and the handing over of the offender to be dealt with as a lunatic. Cases disposed of in this way do not figure in the returns of criminal lunatics, and their omission tends to give an under-estimate of the rôle of insanity in acquisitive crime. On the other hand, these statistics include a fair proportion of professional thieves and burglars who have become insane after many years of crime and imprisonment, and whose anti-social conduct cannot, therefore, be attributed to their mental disorder, even supposing that disorder to be always real and not simulated—for a life of crime naturally does not protect from insanity any more than does a life of honesty. However, even when full account has been taken of these sources of error, we may still accept the statistics of criminal lunacy as giving at all events an approximate indication of the relative importance of the psychopathological factor in the several categories of grave delinquency, and may accordingly regard them as confirming the view that this factor is of little significance in acquisitive crime but of considerable significance in crimes of violence and of lust.

This conclusion is on the whole what we should anticipate if we considered the question from the *a priori* point of view. For it will be generally admitted that, save in very exceptional circumstances, crimes of violence and of lust represent, in the ordinary civilized community, a failure of social adaptation quite different from what is involved in crimes of acquisitiveness. However well rooted be our personal honesty, we do not usually think of theft as very abnormal; we realize that it may have something of the character of an industry about it: the common use in relation to the thief of such an adjective as "professional" implies in fact a realization that criminal ways of satisfying the instinct of acquisitiveness may be closely comparable with legal ways. It is quite different with our feeling about murder or rape; whether it be that these crimes are very much more repugnant to the herd instinct, or that the balance of possible risk over possible advantage is so much greater in them than in theft—whatever be the reason they certainly indicate a much wider and graver divergence from the standard of conduct obtaining in the group, and on that account they suggest a much stronger presumption of pathological origin than is the case with the illicit satisfaction of the acquisitive impulse.

The conclusion, then, to which we are led by this general survey of the facts of criminality is that the relation of insanity to crime is more important from a qualitative than from a quantitative point of view: insanity is responsible for only a quite trivial proportion of acquisitive crime, and, therefore, of criminality as a whole, but the categories of crime in which its influence is most considerable are the categories of gravest social and ethical significance.

For our present purpose, this is the only general conclusion of criminology with which we need concern our-

selves. And it is, perhaps, mainly of practical value as a warning that criminal conduct is not to be considered, *ipso facto*, as evidence of disease or abnormality in the criminal. The fact that crime may be a pathological phenomenon from the point of view of the community does not by any means imply that it depends on pathological conditions in the individual who commits it. There is a much greater likelihood of our finding such conditions in cases of homicidal or sexual crime than in cases of acquisitive crime ; but we cannot assert the presence of a morbid factor in a criminal act of either of the former categories, or its absence in a crime of the latter category, on any other ground than the facts ascertained by the examination of the individual delinquent. In the study of the biological elements of crime the fundamental method must always be that of clinical observation.

CHAPTER III

CRIME IN GENERAL PARALYSIS OF THE INSANE

X In the detailed examination of morbid crime, on which we have now to enter, we have our choice between two methods of procedure. We can classify the facts to be discussed either on criminological or on psychiatric lines. That is to say, we can inquire, with regard to the chief kinds of criminal conduct, what is the frequency of the relation of each kind to psychopathological conditions, and what are the nature and mode of operation of such conditions in the several sorts of crime. Or, on the other hand, we may start from the consideration of the different clinical forms of mental disorder, and examine the types of criminal conduct that are apt to occur in connection with each of them. On the whole, the balance of practical advantage is in favour of this latter mode of presentation, which is also more consonant with the general purpose and spirit of our inquiry. It is this psychiatric method, accordingly, which we propose to adopt in the ensuing pages. There are, of course, certain limitations to its use. The facts of morbid crime cannot always be brought very readily within the bounds of the recognized forms of insanity. Criminal acts, about whose pathological origin there can be no question, are often associated with little or no evidence of mental disorder other than what their own character and circumstances supply: in some instances of this sort, there may be adequate grounds, for example in the personal or

family history of the offender, for regarding the acts as symptoms of a psychosis in a very early and possibly an arrested stage of development, and they can then be placed, more or less confidently, in their appropriate category ; but frequently no such solution of the difficulty is admissible, and we have to leave the facts unclassified. Further, the differentiation of the several clinical forms of insanity is, for the most part, artificial and provisional. With the exception of a very small number of groups, of which general paralysis of the insane is the most conspicuous example, the "mental diseases" distinguished in text-books are not pathological entities, but are for the most part merely clinical types descriptive of the different ways in which disorders of mental function, probably arising from an essentially similar morbid condition of brain, may be combined in their symptomatic manifestations. The discrimination of these types, not being made on any radical or even on any agreed principle, is arbitrary and uncertain ; and it is, in point of fact, notorious that the classifications of insanity, proposed by different alienists, are as remarkable for their number as they are for their diversity of system and nomenclature. On this account, it would obviously be unprofitable, and might be confusing, to adopt any one of these detailed schemes of classification as a method for grouping the facts of morbid crime. Nor is it at all necessary for us to do so. Our requirements in this sort will be sufficiently met if we take a broader view, and content ourselves with a rough division of mental disorders into a very few large and comprehensive classes, some, like general paralysis, being true disease forms, but the majority representing merely symptomatic varieties of insanity, distinguished by headings of generally accepted clinical significance. While such a method can, of course, have no pretension to accuracy or completeness, it will

X

provide a practically useful plan for surveying the morbid conditions related to criminal conduct.

Proceeding on these lines we shall commence with the consideration of the organic dementias, taking in the first place the fairly well-defined disease, general paralysis of the insane.

General paralysis, as has been already observed, differs from most of the so-called mental diseases in being, not a mere clinical variety of insanity, but a definite pathological entity. It presents distinctive physical as well as mental symptoms in the living patient, and is marked by distinctive morbid appearances after death; and further, as has been clearly established, mainly by the brilliant researches of Sir Frederick Mott, it is traceable to a specific cause, namely, the invasion of the brain by the organism of syphilis.

The mental disorder which characterizes the disease is a progressive dementia, a failure of the higher functions of the brain in the inverse order of their evolution. This fundamental process may be revealed by a simple decadence of mind, usually with some degree of fatuous optimism of mood, or there may be superadded to it active symptoms of derangement in the form of more or less absurd and extravagant exaltation of thought and feeling, or, in a minority of cases, an equally extravagant depression. Whatever be the type of the disease, simply demented, exalted, or depressed, it is usually ushered in by indications of impairment of the more recent and more complex mental acquirements, especially those concerned with the adaptation of the individual to his social milieu. Thus, in this prodromal stage, prior to the development of any more obvious signs of unsoundness of mind, there is a tendency to criminal acts of a more or less grave character; and such acts are indeed so frequent in early general paralysis that French authors have termed the

initial phase of the disease *la période médico-légale*. As we shall see, crimes may also be committed in later stages, but they are much less common, partly because the progress of the dementia restricts the capacity for elaborate and co-ordinated conduct, but mainly, of course, because, as soon as the disease is fully declared, the patients are usually sent to asylums.

(i) *Acquisitive crime*.—This is the characteristic form of criminality in general paralysis. Its most common variety is petty larceny, but graver crimes, such as burglary, fraud, forgery, and embezzlement are occasionally observed. As offences of this class, when of minor degree, though technically indictable, are dealt with, for the most part, by courts of summary jurisdiction, the existence of the disease is often overlooked at the time of trial, and there are, in fact, on an average about thirty cases of general paralysis amongst the petty offenders certified insane every year in the local prisons of England and Wales.

Generally the circumstances and execution of the offence show a characteristic silliness; the paralytic will steal an object of no possible use to him, and he will take it in the presence of the proprietor, or of a policeman, or he will forge a cheque for a preposterously large sum. Exceptions to this rule are, however, by no means infrequent: patients in the initial stage of the disease occasionally commit robbery or fraud with a fair amount of cunning, but even in such instances there is almost always some detail in the carrying out of the crime which reveals the essential dementia. Both these points are well illustrated in a case described in detail later on (*Obs.* 2, p. 34). The mixture of skill and ineptitude may also appear very strikingly in criminal conduct which is indirectly connected with the disease, as when a paralytic blunders in his accounts or loses money, and then em-

bezzles to make good the deficit ; in cases of this sort the fraud may be committed in a relatively lucid phase and may have an appearance of intelligent execution, while the error it is designed to cover is stamped with the character of dementia.

The predominance of the instinct of acquisitiveness is evident in all stages of the disease, and the more elaborate crimes referred to above are linked by cases intermediate in complexity to the more simple expressions of the impulse—the automatic theft and the rubbish-gathering of advanced dementia.

In the great majority of instances crimes of acquisitiveness are committed by exalted, or at all events by optimistic paralytics, and very rarely by patients suffering from the melancholic form of the disease. This fact has led some observers to suppose that the act is the logical consequence of the delusional beliefs : the patient imagines that he has boundless possessions, and when he sees something that he has a liking for, he fancies it is his, and naturally takes it : his insanity of action, it is said, is the result of his insanity of thought. It is clear, however, from clinical experience, that such an interpretation is quite untenable. As was remarked above, offences of acquisitiveness are very frequent in the initial stage of the disease, long before the development of delusions of exaltation. And they are common in purely demential cases, where there exists throughout merely a mood of vague optimism without any definite delusional ideas at all. It is true that a paralytic who has committed an offence of this sort will often assign some motive of a delusional or quasi-delusional character to justify his act ; but it is easy to show in such cases that the explanations are merely *ex post facto*, for the patient can be readily made to change their tenor by acting on his facile and unstable emotional state.

The following concrete instance will illustrate this point.

Obs. 1. J. F., male, aged 55, painter by trade. The patient stole a piece of bacon from a stall outside a shop in a large thoroughfare, in broad daylight: he simply picked the bacon up, hid it under his coat, and walked away: the shopman stopped him, whereupon he replaced the bacon on the stall, and waited till the police came and arrested him. He was tried by summary jurisdiction and sentenced to a short term of imprisonment. On reception into prison he was found to present typical physical signs of general paralysis, and to be very demented, being unable, e.g., to name the months in correct sequence, to calculate his earnings over more than two weeks, etc.

Asked why, being an honest man, he committed a theft, he said he was in drink and did not know what he was doing. In further conversation about his mode of life, he said that he was a hard-working man, devoted to his family, that he had not taken a drop of liquor for years; he became emotional and lachrymose on the subject of his children. Asked now why he stole the bacon, he said it was to take it home to his children who had nothing to eat. Questioned about his work, he said that he was a splendid workman, got good wages, had saved money, had £15 in the bank; he was beamingly optimistic. Asked now why he stole the bacon, he said that he did it for a joke. Reminded of his other explanations, he said that he did not know why he stole it, "it must have been for a joke."

As we see, then, that acquisitive crime may occur in general paralysis in the absence of any delusional ideas which can be held to explain it, and that, even when such ideas are expressed, their relation to the criminal act appears to be merely casual, we may reasonably infer

that the primary fact is the morbid impulse. The nature and origin of this impulse will be more conveniently considered when we have discussed the other forms of criminal conduct related to the disease.

(ii) *Homicidal crime*.—In contrast with crimes of acquisitiveness, homicidal offences are very rare in general paralysis. A rough indication of their infrequency may be given by the fact that, amongst the 631 male patients committed to Broadmoor in the last twenty years for murder, attempted murder, and manslaughter, only six were suffering from this disease.

The cases of homicidal crime in general paralysis are divisible into three groups:—

(a) Those in which the criminal act is incidental to the pursuit of an acquisitive, or at all events an expansive, end ;

(b) those due to an excessive reaction against external resistance or irritation ;

(c) those which depend on a primary homicidal impulse.

The first group includes several instances of murder committed by paralytics in the initial phase of the disease in connection with more or less well arranged schemes of robbery. Such cases are of considerable medico-legal importance, because the criminal act, in its aim, circumstances, and execution, may bear a very close resemblance to the act of the ordinary sane delinquent, and the resemblance may be increased by the subsequent conduct and attitude of the culprit. This point emerges very clearly in the following observation:—

Obs. 2. W. S., male, labourer, 54 years of age. Convicted of the murder of an old woman, apparently with the intent of robbery. The patient had been out of work for some time, and was living on the dole, eked out by occasional help from a married sister, who occupied rooms in the house where the victim also lodged. She

was in receipt of an Old Age Pension, and was reputed to have some money hoarded up. The patient, who slept at a common lodging-house in the neighbourhood, was accustomed to go daily to his sister's for food, had often met the old woman, and was well acquainted with her habits and the routine of her life.

On the evening of the murder, the patient had tea with his sister, a young son of the latter and the old woman being also of the party. It was a Friday evening, and the victim had drawn her week's pension earlier in the day. Between 6 and 6.30 o'clock, the old woman went up to her room on the upper floor, this being about her usual hour for going to bed. A few minutes later, the patient left the house, and the sister and her son went out shortly after him. Early next morning a neighbour, going up to the old woman's room, found her lying on the floor with her skull battered in and with wounds on her throat. She was fully dressed, and the light was burning in the room. The door had been forced open. There was no evidence of anything having been stolen, but the room had been rummaged in a way suggestive of robbery. The woman died without recovering consciousness. On searching the room, the police found a pair of fur-lined gloves, which were identified as the property of the patient, and he was accordingly arrested. He denied having had any hand in the murder, and said that on leaving his sister's rooms he had gone back to his lodging-house, that he had played dominoes there with two other men until 11 o'clock, when he went to bed, and this story was in fact confirmed by the evidence of the men in question so far as concerned the time from a little after 8 o'clock. The patient's clothes were stained with blood, which he accounted for by pointing out that he suffered from piles.

On being confronted with the fact that his gloves had

been discovered in the murdered woman's room, he immediately asserted that the police had put them there. Soon after his arrest, he volunteered a second statement to the effect that he had not committed the murder, but knew who had done it, that it was a Jew, that he had seen the Jew come out of the house about a quarter of an hour before midnight, and that he had had a fight with him. Except for the absurdities involved in this latter statement, and for the stupidity of leaving the gloves on the scene of the crime, the case had thus very much the appearance of an ordinary sordid murder for motives of robbery, and the patient's character and antecedents were such as are commonly associated with the perpetrator of a murder of this sort. The defence accordingly did not raise the plea of insanity, but contested the case on the facts, and put the patient into the witness-box to tell his own story. His evidence illustrated very strikingly the extent of his dementia, as may be seen from the following sample. Questioned about his encounter with the Jew, whom he said he saw coming out of the house while he himself was standing at a shop on the opposite side of the street, he replied in this style :
" Q. Is it true you were outside the tobacconist's shop ?
A. Yes, it's the honest truth I was outside the tobacconist's shop. Q. What night was that ? A. The Friday night. Q. What time was it ? A. Ten minutes to twelve. Q. Then how can you say you were in your bed at that time in the lodging-house ? A. That's where I made the mistake. Q. Which is right : Were you in bed or were you not ? A. I was in bed. Q. Then is it true you were outside the tobacconist's shop or not ? A. Yes, I was outside the tobacconist's : that is the honest truth. Q. At the same time you were in bed ? A. No, I couldn't be in two places at once."

As this characteristic dementia was associated with

distinctive physical signs of general paralysis, and with positive Wassermann reactions in the blood and cerebrospinal fluid, the nature of the case was clear, and the patient, who had been found guilty and sentenced to death, was reprieved and sent to Broadmoor. He rapidly became more demented, with puerile delusions of exaltation, and died within a year. As long as he was able to talk in any coherent way concerning the murder, he persisted in his story about the Jew, and since robbery was the motive which he attributed to this fictitious personage, it may be presumed that he had himself this motive in killing the old woman.

The very few other recorded cases of murder by general paralytics from acquisitive motives present much the same characteristics as appear in the above observation; there are similar clumsy attempts to establish an alibi, and there is a similar persistence in an absurd assertion of innocence in face of conclusive evidence of guilt. In these points the attitude of the paralytic criminal resembles that of the ordinary criminal, and differs from that of most insane delinquents.

In the cases which we have just been considering, where the primary impulse to the criminal act is acquisitive, the disease is ordinarily, as in purely acquisitive offences, of the exalted or optimistic type. This is also the type in most of the cases of the next group—the cases in which paralytics commit crimes of violence from motives of resentment. Thus some real or fancied opposition to his extravagant pretensions may provoke the paralytic to violent reaction. One Broadmoor patient, for example, imagined that he had won an impossible number of military decorations, and made an attack on a person whom he suspected of illegally detaining them. In rare instances this delusional resentment may persist long enough to lead to more or less premeditated acts of

violence, as in a case recorded by Marondon de Montyel¹ where an exalted paralytic made a well-planned attempt to murder a friend, against whom he had an insane grievance : the patient had offered to his victim, who was about to get married, the use of his penis, to which he attributed very exceptional qualities : losing the power of erection soon after, he suspected his friend of having substituted an inferior organ. In more advanced stages of the disease, paralytics may commit homicidal acts, in the same way as low-grade imbeciles may do, through excessive and unintelligent reaction to trivial irritation. For example, amongst the nineteen patients sent to Broadmoor within the last twenty years for killing fellow-inmates in other asylums there were two cases of general paralysis : in one of these cases the patient was annoyed by the snoring of his victim, and accordingly went to his bedside and hit him on the head with a chamber utensil ; in the other case, the circumstances of the crime were similar, though the immediate cause of annoyance was not apparent. Allied to the cases of this group are the instances where demented paralytics commit murderous acts under the influence of absurd suggestions ; in an observation, for example, recorded by Kaes,² a paralytic, having heard that death by strangulation did not occur under nine minutes, proceeded to test the statement by choking a child.

We now pass to the consideration of the cases of general paralysis in which crimes of violence are the direct result of a primary homicidal impulse. In these cases the disease is of the melancholic type, either throughout its whole course or at all events over a considerable portion of the prodromal period, in which the criminal

¹ Marondon de Montyel, in *Ann. d'hyg. pub. et de Méd. lég.*, 1883.

² Kaes, in *All. Zeitsch, f. Psych.*, 1896.

acts are perpetrated. The following summarized observations will illustrate the characteristics of homicidal crime in this type of paralysis.

Obs. 3. J. S., aged 36, painter, latterly working as collier. Murdered his 2-year-old daughter by cutting her throat. On the morning of the crime the patient's wife was out shopping, and he was at home with the children. He went to a neighbour's house and borrowed a cobbler's knife, as he had done on previous occasions. He then went to the bedroom where his children were playing, took the little girl on his knee and drew the knife across her throat. Immediately afterwards he returned to his neighbour's house and said to him, "I have done it. I have killed my daughter Laura." The patient had become strange in manner, irritable and depressed, about a year before the murder, and was under asylum care as a case of melancholia for three months. After his discharge, which was four months before the crime, he became very intemperate, and fell out of work. On admission to Broadmoor, he was dull, depressed and resistive, with hypochondriacal delusions of an unorganized sort, and presented physical signs of general paralysis, dying in epileptiform convulsions fifteen months after the crime. It was never possible to elicit from him any information about the murder.

Obs. 4. E. R., aged 45. Female, married. Made a sudden attack on her 14-year-old daughter, striking her on the head with a hatchet. The patient had been irritable, dull, and muddled for the previous twelve months, and had become addicted to drink. Menstruation was irregular and occasionally excessive. On admission she was demented, with vague ideas of persecution and drugging, and at times refused her food. She appeared to have no recollection of the crime. Eighteen months after the crime she died in a convulsive seizure.

In some cases of paralytic murder it may be doubtful whether the act is the expression of a definite homicidal impulse or represents merely a muddled and inco-ordinated attempt to achieve some indifferent or helpful aim, just as occurs sometimes in the automatic phase of epilepsy. The following observation is of this ambiguous character.

Obs. 5. J. R., aged 41, fish salesman. Murdered his 2-year-old child by battering in its head. The murder was committed one evening when the patient was alone with the child in his lodgings, the mother having gone out to shop. Fellow-lodgers, hearing screams and the noise of hammering in R.'s rooms, forced the door and found the patient standing naked over the child and beating it with his fists. They ran for the police, and on returning found that the patient had apparently washed the child and scrubbed the kitchen. He was confused and excited: when asked what he was doing, he replied, "I've done it, I've done it: it's my wish it should be done." When charged at the police station about an hour later, he said, "I did do it, I thought I was doing it for the child's good," adding afterwards, "Wilful murder? You must be mad. I thought the baby had a nerve. I bit it through the mouth and on the top of the head." (A portion of the child's lip had in fact been bitten out.) The only account of the affair that the patient could give in his more rational moments was to the effect that while he was washing himself and "thinking over one thing and another," he "got awfully low in himself," that he fancied the child had "something to do with its head," that he then became confused and "lost himself altogether" till he was in the police station.

R. had been queer in his manner and actions for some two and a half years, had become moody, depressed and

irritable, on one occasion had jumped out of a window in his night-shirt, had threatened suicide. He was constantly worrying about business troubles, and of late had suffered much from insomnia. He had been abstemious for about a year before the crime, but had previously been a very hard drinker, had delirium tremens, and then and subsequently had suffered much from indigestion. On admission to Broadmoor he was depressed and mentally enfeebled, and presented physical signs of general paralysis. He rapidly became very demented, and died in a congestive seizure sixteen months after the murder.

It will be remarked that in Observations 3 and 5 there was a clear history of intemperance, that in Observation 3, though there was no record of lead-poisoning, the patient was a painter and may, therefore, have suffered from this condition as well as from alcoholism, and that the woman, whose case is summarized in Observation 4, was entering on the period of the menopause when she committed the murder, and was also addicted to drink. The significance of these facts will be considered presently, when we discuss the organic sources of morbid impulse in paralytic crime.

To complete this survey of homicide in general paralysis we may note that in some very exceptional instances, a realization of commencing brain failure and of consequent inability to earn a livelihood may lead a patient in the very early stage of the disease to kill his children in order to save them from penury. The Broadmoor records include one case of murder which may be attributed to this relatively sane motive :—

Obs. 6. S. J., aged 29, watch-case maker. Cut his infant child's throat. When arrested gave as his reason for the act that the child was better dead than starving. The patient was a very intelligent man and an expert in

his very skilled line of work. For some six months before the crime he had been increasingly conscious of the failure of his technical ability and of his power of application, and he had sought medical advice for these symptoms, but without relief, so that he had become convinced that his case was hopeless. Admitted to Broadmoor as a case of melancholia, he remained mildly depressed for some months, then developed physical signs of general paralysis, with grandiose delusions, and died in a couple of years.

In connection with homicide in this disease, reference may be made to the similar but even rarer conduct disorder of suicide. It has, indeed, been suggested by some authorities that suicide is not infrequent in the very early phase of the disease, when it is committed from the same sort of motive as appeared to be operative in our last quoted case of murder—that is to say, from the consciousness of impending insanity. However that may be, it is generally agreed that, apart from such comparatively rational cases, suicidal acts are quite exceptional in this affection. From the very few recorded cases it would appear that as a rule suicidal attempts occur in the melancholic form of the disease, though occasionally the opposition to the pretensions of an exalted paralytic may lead to a more or less serious act of this sort. The essential dementia of the disease is apt to appear in the way in which the suicidal attempt is made, as when, for example, a paralytic jumps into the water to drown himself, but scrambles out because he recollects the risk of rheumatism.¹

(iii) *Sexual Offences.* The persistence of the sexual impulse to a normal, and perhaps even to an exaggerated degree, in the early stages of general paralysis, leads occasionally to crimes of lust, either minor offences, such

¹ Mendel, *Die Progressive Paralyse*, Berlin, 1880.

as indecent exposure—which, however, is more often an act without any sexual significance—or grave sexual assaults. These offences may be related either to the exalted or to the melancholic forms of the disease, and are commonly committed, like the automatic thefts, under conditions which sufficiently indicate the dementia of the culprits. The more serious crimes of this class appear to be relatively infrequent; during the present century only two instances of sexual crime—one case of rape and one of incest—committed by general paralytics have been included in the Broadmoor admissions.

(iv) *Other Offences.* The only other grave offence which is of any importance in connection with general paralysis is arson. In all the Broadmoor cases where this was the form of delinquency the disease was of the exalted type. Sometimes the act appears to be the expression, as frequently in the imbecile, of a silly desire to enjoy the sight of a blaze, but occasionally it is committed in an insane attempt to effect a definite object, as in one case where the patient set fire to a hayrick for the purpose of clearing the stack-yard.

From this survey of the facts of criminality in general paralysis, we now pass to the consideration of the underlying conditions which determine the character of conduct in this disease. Our discussion will be concerned mainly with two categories of crime—crimes of acquisitiveness, which we have seen to be by far the most frequent type of paralytic delinquency, and crimes of violence, which, on the contrary, are rare and exceptional. In comparing these two varieties of crime, as they occur in general paralysis, the first point we have to note is that acts of acquisitiveness are almost always related to the optimistic form, or to optimistic phases of the disease, while acts of violence, so far as they depend on a primary homicidal

impulse, are regularly related, as are also suicidal acts, to its melancholic form. From this practically constant association, we may reasonably infer that impulses of acquisitiveness are the expression in conduct, as the delusions of exaltation are the expression in thought, of an optimistic emotional tone; and that, similarly, homicidal and suicidal impulses, and hypochondriacal and persecutory delusions, are manifestations of a depressed, pessimistic affective tone. Further, it will be recalled that in paralytic crime, as we shall also find to be ordinarily the case in other sorts of morbid crime, the impulse is the earlier and more constant expression of the emotion, of which, indeed, it is rather a constituent, while the corresponding disorder of thought is later in appearing, or may not appear at all.

It is, of course, notorious that in the large majority of cases of general paralysis, the affective tone is constantly or predominantly optimistic. This is obvious in the exalted paralytics with delusions of boundless wealth and superhuman endowments of body and mind; it is evident, too, though less obtrusively, in the numerous cases of simple dementia, most of which exhibit a happy, facile, self-satisfied temper, and show in conduct the acquisitive tendencies that go with that temper. Only in a small minority of cases, estimated by Clouston at from 3 to 4 per cent., is the prevalent mood one of depression.¹ This fact provides an obvious explanation of the character of crime in general paralysis; because the affective tone is ordinarily optimistic and very rarely depressed, so impulses of acquisitiveness are the rule, homicidal and suicidal impulses the exception.

It is, accordingly, in the conditions which determine the emotional tone in the disease that we have to look

¹ Clouston, *Mental Diseases* (sixth ed.), London, 1904.

for the source of its conduct disorders. There is no reason to suppose that these conditions are connected with the character or distribution of the morbid changes in the brain tissue. The brain lesions of the disease may, no doubt, account for one feature of the emotional state, namely for the quality of excess which is manifest alike in cases of exaltation and in cases of depression, and is merely a character of dementia; but it is difficult to conceive how they can determine the nature of the emotional tone in itself. Nor is it in the least necessary to have recourse to any such hypothesis, for we can explain the facts of affective disposition in paralysis in a much simpler and more obvious way by referring them to the normal source of emotion, that is to say, to the state of the organic life.

To ascertain what measure of support this explanation finds in clinical experience, we shall begin with the consideration of the exceptional cases, those in which the mood is depressed and the impulses are homicidal or suicidal. In the great majority of the cases of this type recorded in medico-legal literature, it is the rule to find, as in the illustrative observations from the Broadmoor material quoted in the present chapter, that the disease was associated with some condition of a kind that might be expected to modify the affective tone in a pessimistic direction. And a review of the opinions expressed by practically all the authorities who have investigated the melancholic form of paralysis, shows that the same significant association is a general fact of clinical experience in this malady. Thus it has been observed that a depressed affective tone is very frequent in general paralysis where there is a history of alcoholism. Talon,¹ in 100 cases of the disease in alcoholics, found only 12 with optimistic delusions. So also with the less frequent intoxications,

¹ Talon, ref. in *Ann. méd. psychol.*, 1883.

such, for example, as chronic lead poisoning ; Devouges¹ and Régis² have noted the frequency of a pessimistic and malevolent temper in general paralytics who have suffered from this form of intoxication. Visceral disease, again, has been observed as a common accompaniment of emotional depression in paralysis ; and it has been frequently pointed out that when the disease occurs after the prime of life, especially if there are indications of premature senility, it is very often of the melancholic type.

From the consideration of this mass of clinical evidence we may infer with a considerable measure of probability that the exceptional occurrence of a persistently depressed emotional tone in general paralysis is ordinarily a result and expression of a disorder of the organic processes which are the basis of the affective personality ; there is a perversion of these processes, akin to what we may suppose to exist in the decadence of age or in general intoxications, and, accordingly, the emotions, impulses, and thoughts of these paralytic demented present very much the same characteristics which, as we shall see later on, belong to the emotions, impulses and thoughts of the chronic alcoholic and the senile.

Conversely, when no such special morbid conditions exist, and when the organic life is healthy, the emotional tone will ordinarily be optimistic. It is so in the great majority of the cases of general paralysis, which is typically a disease of the years of fullest vital activity : in its early period there is usually a normal state of visceral function, and it has been shown by Mott,³ that even to an advanced stage of the disease, the sexual glands, which exercise a notably potent influence on the affective life,

¹ Devouges, in *Ann. méd. psychol.*, 1857.

² Régis, in *Ann. méd psychol.*, 1881.

³ Mott, *Archives of Neurology*, vol. viii., 1922.

retain their activity. This state of vigorous organic function is reflected in the optimistic mood which is characteristic of the disease in its most frequent type, and it is reflected also in the disorders of conduct and of thought which go with that mood, that is to say, in crimes of acquisitiveness and in delusions of exaltation.

CHAPTER IV

CRIME IN SENILE INSANITY

We saw in the last chapter that the brain degeneration, which is the essential process in general paralysis, occurs most commonly at a time of life when the vital activities are ordinarily in full vigour, so that their reaction on the affective personality tends naturally to generate the optimism of mood and the predominance of acquisitive impulse which are, in fact, characteristic of the great majority of cases of this disease. In senile insanity, which is the form of mental enfeeblement that we have next to consider, the conditions are entirely different. The dementia of old age, in contrast with the dementia of general paralysis, is the dementia of an organism whose vital energy is waning ; and the disorders of feeling and will that accompany it and take their colour from this state of organic function, show accordingly a characteristic trend towards emotional depression and towards the impulses that belong to that mood. This is, of course, a commonplace of human experience ; pessimism is notoriously the note of the years "when the grasshopper shall be a burden and desire shall fail." In the sphere of conduct this effect of age on the emotional tone is strikingly illustrated by the increase with advancing years of the tendency to suicide. Thus it is a constant feature of the vital statistics of all modern civilized states that the suicide rate, which is low in early life, rises regularly in each successive age-group, to reach its

maximum level over sixty-five.¹ Suicide, no doubt, is a phenomenon of very complex causation, and its relation to age may be, and indeed, almost certainly is, determined in part by social as well as by purely biological factors, but it is difficult to suppose that this constant and universal feature of its incidence is not in the main an expression of the failure of vital energies with the onset of senility.

Considered in this light, the increased suicidal tendency in later life is of peculiar interest in connection with the question of senile crime, which exhibits in psychopathological cases a similar predominance of the impulses related, as we may assume that the suicidal impulse is related, to a depression of the affective tone. The most important and most characteristic of these impulses is the homicidal impulse, and homicide, in point of fact, is a notably frequent form of the morbid criminality of old age.

The clinical features of senile murder, and the circumstances attending it, vary a good deal according to the degree of the associated disorder of intellect. In instances where the dementia is profound, the homicidal act may be committed in a sudden impulsive outburst without any antecedent or accompanying evidence of related delusional ideas. The following case was of this type :—

Obs. 7. E. S., aged 75, master mariner. Attempted to murder his wife. Patient came of a normal stock, and had himself been a healthy, vigorous man up to his seventieth year, when he began to fail physically and his memory was noticed to become rather defective. Two years later he was said to have had a transient attack of aphasia, after which he remained somewhat

¹ Morselli, *Il Suicidio*, Milan, 1879. Ogle, in *Journal of Statistical Society*, 1886. Durkheim, *Le Suicide*, Paris, 1897.

more enfeebled mentally. Some months before the crime he showed indications of morbid activity, was restless at night, and talked much of vague business projects. He then became increasingly dull and demented, with occasional phases of irritability and excitement. In one of these phases he made a sudden attack on his wife, seizing her by the throat and inflicting on her several severe wounds with a safety razor blade which he had secreted in his bed. After the crime, and up to the time of his admission to Broadmoor, he was confused, apathetic, and unable to give any coherent account of his conduct, of which he seemed to have at most a very blurred recollection. He remained in this condition throughout his detention, but had occasional phases of relative lucidity, in some of which he expressed delusions that his food was poisoned. He was also destructive at times, and would tear up his sheets and twist them round his throat, saying that the room was full of devils who told him to do this. He became increasingly demented and feeble, and died some two-and-a-half years after admission.

Sometimes senile demented who have committed homicidal acts in a confusional state similar to that described in the above observation, may subsequently show a temporary improvement sufficient to make them accessible to examination, and they are then found to have no recollection, or at most a very fragmentary and blurred recollection, of the incidents and motives of their crime. They may, however, either at this time or later on, express delusions of poisoning or of bodily disorders referred to malign agencies, which, if present before the murder, might have seemed to be in some sort of logical relation to it. As in the aberrations of conduct met with in the other forms of mental enfeeblement, the true connection of the impulse and the delusion in

such cases is clearly that of dependence on a common basis in the disorder of organic function.

In contrast with these cases of quasi-automatic murder, the homicidal act may be committed in a relatively lucid condition, with evidence of more or less premeditation and deliberate intent, and its details may be clearly recalled in memory. This is naturally more apt to occur when the intellectual enfeeblement is of comparatively moderate degree, so that it still allows the reflection of the morbid organic state to take shape in delusional conceptions, usually, however, of a very rudimentary and unsystematized character. These delusions, which represent a further development of the suspicious and timorous tendencies common in morbid senility, are frequently accompanied by more or less relevant hallucinations, especially of hearing. The following observation illustrates the characteristics of this type of senile murder. ?

Obs. 8. G. D., aged 72, fitter. Murdered a man in whose house he lodged, and attempted to murder the man's wife. Patient was an old soldier, and had served in the same regiment, and afterwards, in civil life, worked in same factory with his victim. He was a widower without children, and for many years before his wife's death had lived apart from her. Four years before the tragedy, the patient, who was living on his pension and his savings, thought that he was being robbed by the people with whom he lodged, and accordingly left them and rented a room in the house of the man he killed. After staying there about two years, he got suspicious that some of his things were disappearing, and he went to live with a niece, but within a few months began to complain of people laughing and jeering at him whenever he went out, and said that vegetables were being stolen from his allotment garden. On account of these troubles

he went back to his quarters in his old comrade's house. He occupied a basement room which he allowed no one to enter, preparing his own meals and doing everything for himself. He appeared to be on quite friendly terms with the people in the house, and, except for his rather more solitary habits, seemed to them to be much the same mentally as he had been. One evening, about two months before the crime, he came to the door of his landlord's kitchen, and, having asked the man's wife what time it was, remarked to her, "If you belonged to me, I would knife you." A week after this incident he was found in the lavatory with a self-inflicted wound in his throat. He was detained for some weeks in the infirmary, and was then discharged and returned to his lodgings, where he pursued his usual mode of life up to the time of the murder. In the afternoon of that day he came upstairs to the kitchen with a carving knife in his hand, and at once stabbed the landlord and his wife, killing the former. He then went back to his own room, put the knife on the table, and went to the police station, where he stated that he had "murdered a man and wife," giving the address of the house and intimating where the knife would be found. Later on he said, "I was waiting for the daughter to do her in too; they kept on pulling up the floor and shaking it like that (making motions with his hands); they turn on the taps as well and let the water run; then they got the lawn mower and pulled it up and down the passage, and made a noise. I couldn't stand it any longer."

While under detention, the patient was quiet and orderly, and made no delusional complaints. He was extremely reserved, and declined to talk about his crime, merely saying that he had been worried and annoyed, and that his victims "had asked for it." He became

gradually more demented and physically enfeebled without active mental symptoms.

A form of senile murder which, from its frequency and its distinctive features, demands special consideration, is that associated with delusions of marital infidelity. Its clinical characteristics are shown in the two following observations.

Obs. 9. H. Y., aged 78, gardener. Murdered his wife and son. The patient, who came of a reputedly normal stock, had been a hard-working and sober man, and had not shown any signs of insanity until he became somewhat enfeebled in mind a few years before the crime. He then began to express delusions about his wife's conduct, saying that she had repeatedly tried to poison him, that she had put a "cinder," specially shaped, into his hash in order to choke him. He also accused her—she was 77 years of age—of immoral relations with their son. These delusions were associated with hallucinations of hearing—voices, by day and night, telling him to commit suicide, to kill his wife, to perpetrate other crimes. He got up one night, in obedience to these voices, split his wife's head open with an axe, and stabbed the son in his bed.

On admission to Broadmoor, he was demented, with defective memory, irritability and occasional confusion, but was able to give a coherent account of the crime. He would repeat his delusions about his wife, saying he had often seen her act in a suspicious manner with the son, and had overheard the latter tell his mother to turn up her clothes. His physical and mental condition rapidly deteriorated, and he died two months after reception.

Obs. 10. E. L., aged 69, engineer. Attempted to kill his wife and to commit suicide. The patient belonged

to a family without known nervous taint, and had himself been a steady, industrious man. He had never shown any indications of mental disorder until a couple of years before the crime, when he began to be very querulous and fretful, with signs of failing memory and slowness of thought. He also occasionally hinted vaguely at suspicions of his food being drugged and of things being stolen from his house. His wife was about ten years younger than the patient and had been married to him nine years, being the widow of his deceased brother. The patient had not expressed any definite doubts of her chastity, but had become inquisitive as to her movements and markedly uxorious for some months before his homicidal attempt. This attempt was made suddenly and without any preceding quarrel: the woman was busy cooking, when the patient came behind her, gave her a gash in the throat with a razor, and inflicted a wound on himself with the same weapon. He was very emotional and lachrymose immediately afterwards, and said that the idea of killing her had come to him only a few moments before he attacked her; he had been brooding over her conduct, and thought that, as she was going wrong, the best way to "stop her downfall" was that they should die together. He said that he knew she had been misconducting herself with different men for the past two years; he had no proofs—"nothing you could call proof"—but there were a lot of suspicious circumstances. For instance, one of her lovers, a married man, who lived in an adjoining house, complained of an escape of gas in his cellar; but when the patient examined the gas-pipe he found that it had been tampered with—this was to give the lover a pretext for taking the woman down to the cellar for immoral purposes. Again, when the patient, who had been away in hospital, came home, there was a knocking at the door

the first night after his return, just at the hour when one of the paramours would be coming off his work shift. His stepson had given his wife some powders, and the patient found shortly after that his own virile power had decreased, which must be because the powders had been secretly administered to him.

Soon after his admission to Broadmoor, he began to complain of "rumours" annoying him day and night: these rumours described in detail the amorous adventures of his wife; they said that she had made a bigamous marriage with one of the suspected lovers, that he was a stronger man than the patient, and that she had never known what marriage was before. The "rumours" also recalled the incident of his wife, early in the marriage, having had a uterine hæmorrhage which she explained at the time by attributing it to the change of life, but which he subsequently suspected to be due to a miscarriage after a pre-matrimonial amour: the "rumours" now asserted that the blood which the patient had seen in the bed was the blood of a new-born infant, that the patient had murdered this bastard, tearing it asunder and throwing the mangled body on the bed. According to his account, these "rumours" did not begin till he had been some months in the asylum: there were never any before he made the attack on his wife.

In the next chapter, when dealing with alcoholism, which is by far the most important causal condition in homicidal jealousy, we shall see that the delusions and suspicions of marital infidelity arising on the basis of that chronic intoxication, are very similar in character to those described in the above observations. In alcoholism, however, the morbid ideas usually disappear after a longer or shorter period of asylum detention, as a consequence of the withdrawal of the toxic agency, while, naturally, they tend to persist when they depend

on the permanent and progressive degeneration of old age; they may even, as in the second of the above observations, undergo further elaboration.

X
A further difference between senile and alcoholic jealousy is that in the former the dementia is usually too marked to allow of the development of any complex and more or less coherent delusional system, such as may be evolved when there is still a certain amount of available energy for morbid mental combinations. It is an apparently paradoxical consequence of this fact that the delusions of marital infidelity are usually of less intrinsic absurdity in senile than they may be in alcoholic cases; the senile patient is satisfied with very slender proofs in support of his suspicions: these suspicions may be extravagant in themselves, as when they impute adultery to an aged and decrepit woman, but the evidence purporting to confirm them is generally within the bounds of possibility. The alcoholic, on the contrary, seems frequently to be impelled to a more elaborate rationalization of his morbid impulses, which may lead him to the most preposterous beliefs. One patient, for instance, whose jealousy was due to alcoholism associated with presenile degeneration, adduced as a conclusive proof of his wife's guilt, and a justification for his attempt on her life, that he had discovered in her bed the trace of a seminal emission which exactly reproduced the outline of her paramour's genital organs.

The persistence, in an exaggerated and morbid form, of the sexual instinct in old age, which is suggested by the frequency of senile jealousy, also finds expression in the notorious tendency to crimes of lust in this period of life. Indecent exposure and offences against children of either sex are the usual manifestations of this perverted impulse. It is a practically important point in connection with such offences that they are apt to occur in a

relatively early stage of senile degeneration, when there may be little, if any, indication of intellectual enfeeblement, and when the only evidence of the morbid condition may be the failure of self-control revealed by the criminal acts. As we shall see later on, sexual offences against children are also frequent in alcoholism, thus constituting a further point of resemblance in the criminality of these two varieties of dementia, in which disorder of the organic functions appears to be the direct source of the morbid manifestations in feeling, impulse and thought.

Apart from homicidal and sexual offences, the crimes related to senile insanity are of comparatively little importance. As in other conditions of mental enfeeblement, crimes of acquisitiveness are sometimes committed by senile demented, especially when the dementia is associated with an indifferent or exalted emotional tone; and acts of destructiveness, such as arson, are occasionally met with in this condition.

CHAPTER V

ALCOHOLISM AND CRIME

In the preceding chapters, in which we discussed general paralysis and senile insanity, we saw that these diseases are primarily and essentially organic deteriorations of the brain, which may be manifested, in derangement of function, simply by symptoms of mental enfeeblement, or may present, over and above these symptoms, disorders of a more active sort in conduct and in thought. The acute and chronic intoxications by alcohol, on the consideration of which we have next to enter, are of fundamentally similar nature, and may be regarded as belonging to the same category: like general paralysis and senile insanity, they are organic dementias in which impairment of mental activity is the constant and may be the only obvious manifestation, and in which morbid acts and morbid ideas, when they occur, are mostly accessory phenomena, and may be ordinarily interpreted as expressions of the affective tendencies and of the modes of visceral function from which these tendencies arise. To this similarity of nature between these morbid groups there corresponds also a significant similarity of origin; alcoholism is due, as is general paralysis, to an exogenous cause, and it shows accordingly the characteristic which belongs to that disease, and in a lesser measure, to senile dementia, of being relatively independent of hereditary influences, thus differing very widely from most of the other forms of insanity.

Before proceeding to the examination of the clinical facts of alcoholic crime, it is necessary to consider briefly certain points in the causation of alcoholism which have an important bearing on its relation to criminality. Alcohol is drunk primarily for the sake of its action on the emotional tone: it is a mild narcotic which, by weakening inhibition and blunting sensibility to unpleasant stimuli originating either within the organism or in the environment, produces a more or less exhilarating effect on the drinker. As I have shown elsewhere,¹ the conditions under which this exhilarating influence is ordinarily sought may be divided into two main classes, giving rise to two types of drinking, which, from the predominant motive in each, may conveniently be distinguished as convivial drinking and industrial drinking. Convivial drinking, the character of which is sufficiently indicated by the qualifying term, is normally intermittent, so that it does not involve any continuous toxic action on the tissues; it does not, therefore, lead to chronic alcoholism, but it often runs on to immediate excess, to drunkenness. In pure industrial drinking, on the other hand, where alcohol is taken in small but frequently repeated doses, as an aid to work, and especially to work of a fatiguing and unpleasant kind, there is no tendency to acute intoxication, but there is a steady maintenance of a noxious amount of alcohol in the blood which in the long run brings about the tissue changes of chronic alcoholism. The distinction between these two modes of drinking is of considerable importance in relation to crime, because, as will be indicated later on, the conduct disorders of alcoholism are mainly connected with chronic alcoholism, or with drunkenness supervening on chronic intoxication, and are, therefore, chiefly dependent on industrial drinking, while convivial drunkenness, in a

¹ Sullivan, *op. cit.*

subject of normally stable brain, is rarely associated with grave criminality, though it may lead to minor forms of delinquency.

The psychopathological conditions resulting from alcoholic excess are, of course, in their essential nature, insanities: drunkenness is an insanity, and the morbid mental states that may accompany chronic alcoholism are also insanities, though they are not so denominated in common parlance, which restricts that term to disorders of mind amounting to certifiable lunacy. Occasionally, no doubt, alcoholism does produce symptoms of intellectual derangement which are sufficiently pronounced and of sufficient duration to come within that category, and cases of this sort form a well-defined but numerically insignificant group in the ordinary asylum population—the group of the alcoholic psychoses proper, comprising delirium tremens, Korsakow's disease, and certain types of more or less chronic delusional insanity. For the most part, however, the mental disorders of alcoholism fail to reach the degree of certifiability, and this mainly for a reason which is of peculiar interest in relation to our present inquiry, that is to say, because these disorders are manifested primarily and chiefly in the sphere of conduct, and so, being unaccompanied by any obvious intellectual disturbance, come more under the notice of the policeman than of the alienist. So that we may sum up the position by saying that alcoholism is a very important cause of insanity if we use that term in its full psychological sense, which will include all the morbid mental symptoms of acute and chronic intoxication, but that it is, on the other hand, a factor of very small account in the insanity of the asylum, and of official statistics.

The distinction between these two conceptions of insanity is worth noting because a neglect of it is a frequent source of confusion of ideas regarding the relation of

alcoholism to mental disease. Thus it is often said that alcohol is an important, or even the most important, cause of insanity, meaning thereby the ordinary psychoses which make up the great mass of certifiable lunacy. In reality, however, it is highly improbable that alcohol plays any direct part in the causation of these affections. There is no evidence that alcoholic excess—whatever be its effect on the drinker's offspring—contributes in any way to the development, in the drinker himself, of dementia præcox, for example, or of manic-depressive insanity. Of course, these psychoses may occur in persons with a history of intemperance, for, obviously, alcoholism does not confer immunity from any form of insanity; but in such cases it is merely a question of antecedence, and not of causal relation. This negative conclusion has been solidly established from the pathological side by Sir Frederick Mott, who has shown that the morbid conditions specifically associated with alcoholic intemperance are very much rarer in asylum patients than in ordinary hospital cases.¹ Cirrhosis of the liver, for instance, was found by Mott in 7·7 per cent. of his hospital autopsies, but in only 1·8 per cent. of asylum patients, these being mainly cases of Korsakow's disease or alcoholic dementia. And the statistical evidence on the point leads to the same conclusion. Thus, during the war, when the system of physiological regulation of the Liquor Trade, enforced by Lord D'Abernon, had brought about an enormous reduction of alcoholism in this country, there was no corresponding decline in certifiable insanity, but, if anything, a slight upward movement in the number of first admissions to asylum care. This is clearly apparent in the accompanying table (V), which shows for the years 1913–1921 the movement of drunkenness and of other alcoholic pheno-

¹ Mott, *Archives of Neurology*, vol. 3, 1907.

mena in comparison with the number of first admissions to pauper asylums. To avoid the obvious risk of fallacy arising from the disturbing influence of military service during the period under review, the figures refer to women only.

TABLE V
ALCOHOLISM AND INSANITY (WOMEN ONLY).

England and Wales, 1913-1921.

<i>Year.</i>	<i>Convictions for Drunkenness.</i>	<i>Deaths from Alcoholism.</i>	<i>Deaths from Cirrhosis of Liver.</i>	<i>Attempted Suicide.</i>	<i>First Admission to Lunatic Asylum.</i>
1913 .	35,765	719	1,665	988	9,372
1914 .	37,311	680	1,773	1,049	9,702
1915 .	33,211	584	1,525	816	9,078
1916 .	21,245	333	1,163	436	8,850
1917 .	12,307	222	808	383	8,702
1918 .	7,222	74	579	319	9,726
1919 .	11,183	84	510	499	9,888
1920 .	15,246	140	562	619	9,759
1921 .	12,892	139	639	291	9,823

CASES OF DELIRIUM TREMENS IN WOMEN.

(Certain Poor Law Infirmaries.)

1913-14 .	.	.	.	.	.	.	213
1914-15 .	.	.	.	.	.	.	190
1915-16 .	.	.	.	.	.	.	102
1916-17 .	.	.	.	.	.	.	54
1917-18 .	.	.	.	.	.	.	18
1918-19 .	.	.	.	.	.	.	11
1919-20 .	.	.	.	.	.	.	25
1920-21 .	.	.	.	.	.	.	19

The prevalence of alcoholism, as measured by the number of arrests for drunkenness, the mortality from chronic alcoholism and from its most common alias, cirrhosis of the liver, the frequency of delirium tremens, and the deaths of infants from suffocation in bed—a mishap highly correlated with maternal intemperance—thus declined between 1913 and 1918 by well over 70

per cent., but the number of fresh cases of certified insanity remained practically constant.

It will be observed that this table also includes a column referring to attempted suicide, and that the figures in the column show a fall from year to year which is closely parallel to the fall in the patently alcoholic phenomena. Attempted suicide is, in fact, the most frequent and characteristic of the graver conduct disorders produced by alcoholism: I have discussed elsewhere ¹ in detail the evidence in proof of this view, and the experience of the war years, as is apparent from the above table, fully confirms its soundness.

These statistics thus bring out with striking clearness the contrast between the insanities which are certifiable, and which are not to any appreciable degree related to alcoholism, and the psychopathological conditions which are specifically alcoholic, and which, while not ordinarily coming within the limits of legal lunacy, are very apt to find expression in serious disorders of conduct. Their significance from this point of view is very great, and it would probably be safe to affirm that in this country alcoholism is, or at all events was before the war, the most important of the individual morbid factors of crime. It is suggestive of the extent of its influence to observe that the decrease of intemperance which began in 1915 has been attended with a perceptible decline in the volume of those forms of delinquency which are specially related to alcoholic excess. This fact is brought out by the figures in Table VI showing the proportion per 100,000 of population, of the several main classes of crime in each year from 1912 to 1921. It will be seen from this table that, while there was a decrease in all categories of crime during the period of the war, this decrease was comparatively slight in crimes of acquisitive-

¹ Sullivan, in *Journal of Mental Science*, vol. 46, 1900.

TABLE VI.

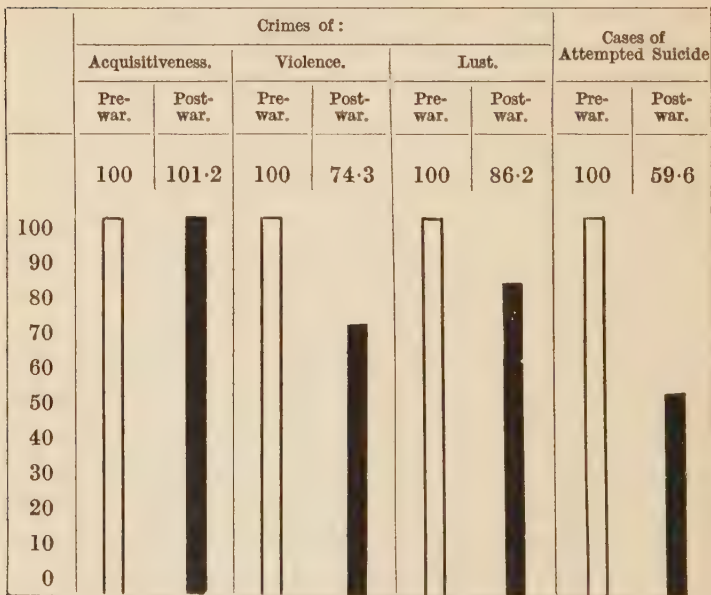
CRIMES KNOWN TO THE POLICE.

Proportion per 100,000 of Population in Years 1912 to 1921.

	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921
Crimes of Violence	5.79	5.43	4.68	3.87	3.53	3.06	3.11	4.12	4.11	3.69
Crimes against Morals (ex- clusive of Bigamy) . .	6.42	6.92	6.27	5.17	4.77	3.57	3.65	4.94	6.04	5.92
Attempted Sul- cide . . .	6.54	6.71	6.74	4.79	3.64	2.86	2.53	3.63	4.66	3.64
Crimes of Ac- quisitiveness .	256.35	242.33	220.62	202.93	219.66	251.21	249.71	226.23	249.61	255.38

DIAGRAM TO ILLUSTRATE TABLE VI

Prevalence of Crimes of Acquisitiveness, Crimes of Violence, Crimes of Lust, and Cases of Attempted Suicide in the post-war period (1919-21) in percentage relation to their prevalence in the pre-war period (1912-14).



ness, and further that such offences have since risen again to their pre-war level. In crimes of violence and of lust, on the contrary, not only was the diminution much more marked, but it has also been more persistent : these forms of crime have been sensibly less prevalent during the post-war years than they were before 1914 ; they show, though, of course, to a lesser degree, the same shrinkage that is evident in the case of attempted suicide. During the post-war years, the most important principle of Lord D'Abernon's policy of physiological control—the shortening *and interruption* of the hours of sale in public-houses and clubs—was continued, at first by regulation, and subsequently by the provisions of the Licensing Act of 1921, with the result that, as may be seen from Table V, the war-time reduction of alcoholism has been substantially maintained. In the absence of any more plausible explanation, it seems reasonable to conjecture that the lower level of homicidal and sexual crime, as also of attempted suicide, in the years 1919–21, as compared with the pre-war years 1912–14, is related to this coincident decrease of alcoholism.

From this brief consideration of the statistical data, we have now to proceed to examine the clinical facts regarding alcoholic crime, dealing in the first place with the criminality related to drunkenness. It has been already remarked that ordinary casual intoxication is not an important cause of grave crime. There are two explanations of this fact. In the first place, in what may be termed normal drunkenness, the successive levels of the nervous system are affected in such rapid sequence that there is relatively little chance of the performance of criminal acts of any complexity. In the second place, the impulses liberated in the temporary dementia of drunkenness are very largely determined, as regards their character and direction, by the state of the organic

life, and since that state is ordinarily healthy in the average convivial drinker, the impulses are more likely to be impulses of acquisitiveness or normal sexual impulses. And so we find, in fact, that, when uncomplicated convivial excess leads to crime, the offences most commonly met with are petty theft, like the theft of the general paralytic, and rape or indecent assault on adults. There are, of course, numerous exceptions to this rule. The self-satisfied mood of the slightly inebriated subject is unstable, and trivial stimuli from without, which would only cause slight and passing irritation to an ordinary sober individual, may produce an exaggerated effect on the emotional tone, and may provoke violent and aggressive reaction: this is the history of the common drunken quarrel, ending in manslaughter or wounding. Further, there is, in drunkenness, as in general paralysis, an amenability to absurd suggestions which may lead to homicidal acts; Prosper Despine,¹ for instance, records a case where one of four drunkards who were carousing together proposed by way of a joke that they should hang the most intoxicated of the party, which they accordingly did.

It may also happen in normal drunkenness, as it sometimes happens in imbecility, that after a theft or a sexual assault, an obscure realization of the possible consequences may lead the criminal to commit murder in an unintelligent effort to escape detection. In such cases the circumstances of the crime, and the conduct and demeanour of the criminal, resemble very closely what we have described in the very similar type of murder in general paralysis.

In the large majority of instances, however, in which drunkenness leads to grave criminal acts, and more particularly to homicide, the intoxication is not of the

¹ Prosper Despine, *Psychologie Naturelle*, Paris, 1868.

normal type which occurs in the average healthy drinker ; it is a pathological drunkenness, that is to say, it is the sort of drunkenness which develops in persons in whom there exists a special susceptibility to the action of alcohol. This susceptibility is shown by a marked predominance of those symptoms of intoxication which depend on interference with the higher mental functions, while the affection of the lower brain centres and of the spinal cord may be relatively inappreciable. Thus pathological drunkenness resembles very closely the type of disordered consciousness that is apt to develop in epilepsy and in other conditions of nervous instability ; and most of these conditions, indeed, involve a predisposition to the occurrence of the mode of intoxication which we are here considering. As they will be fully discussed in a later chapter, it is not necessary to enumerate them here ; it will be sufficient for the moment to illustrate their connection with pathological drunkenness and crime by a typical instance.

Obs. 11. J. K., sailor, 28 years of age. The patient's father suffered from fits which were regarded as epileptic ; a paternal uncle died in an asylum. The patient, who had sunstroke some years before the crime, was an intermittent drinker, reacting morbidly to alcohol. On the evening of the eleventh day of a drinking "burst" he was seen to go home with his wife, being apparently on boisterously affectionate terms with her. During the night he killed her by cutting her throat with a razor as she lay in bed, and made an almost successful attempt to commit suicide with the same weapon. He professed to have no memory of the act, and to be unable to suggest any motive for it. There was no ground for doubting the genuineness of the amnesia, which persisted throughout the period of his penal servitude, when no motive for simulation any longer existed.

This case illustrates very well the characteristics of murder in pathological drunkenness. Insane heredity and sunstroke created a morbid predisposition, evidenced by the man's special reaction to alcohol ; in the dreamy state resulting from a heavy debauch, homicidal and suicidal impulses develop and issue in acts which leave no trace in the murderer's memory. In this instance the main factors of instability—the morbid heredity and the sunstroke—were associated with fairly prolonged drinking, and it is probable that this latter element contributed to the direction of the impulses. But cases are also met with where homicidal acts are committed in pathological drunkenness by persons who are ordinarily abstemious ; this, as we shall see later on, is more apt to occur in subjects of epileptic stock.

In the large majority of instances of pathological drunkenness leading to crime, the predisposition is not due to innate instability, but is itself of alcoholic origin ; it results from the cerebral enfeeblement produced by chronic intoxication. And a large number of the more serious crimes due to alcohol are, in fact, committed in the dream state of a drunkenness supervening on chronic alcoholism. In such cases the characteristic form of crime is murder, most commonly the murder of the wife or the mistress. In typical instances there is an entire absence of conscious motive ; the act is committed in a state of acute intoxication by a drunkard of many years' standing, who presents definite indications of visceral disorder, and may have suffered from one or more attacks of delirium tremens or may have attempted suicide : there is entire amnesia of the crime ; and finally, showing the affinity in nature and origin of the two impulses, the crime is frequently followed by a suicidal attempt. In other cases the loss of memory may be only partial, and there may be a vague recollection of some delusional

motive. Instances of increasing lucidity of consciousness connect these automatic murders to the cases where the crime is a deliberate, premeditated act, consciously associated with definite delirious ideas, generally of a special and characteristic content.

These cases of murder with conscious motive in chronic alcoholism illustrate with peculiar clearness the nature and source of the morbid impulses in this condition, and on that account it will be desirable to examine their salient features in some detail. We may start with the consideration of a concrete instance.

Obs. 12. H. B., fish hawk, 41 years of age. There was nothing of note in the man's family history, and his long resistance to alcohol is presumptive evidence of a normally stable brain. He had been a steady drinker for some twenty or twenty-five years, and during the last two or three years preceding the crime which closed his alcoholic career, he had several attacks of delirium tremens; also, without actual delirium, he often suffered from hallucinations, tremors and insomnia. When under the influence of drink he had latterly shown a very violent and irritable temper, and had expressed suspicions of his wife's chastity; he would then accuse her, watch her movements, threaten, and sometimes assault her; on two occasions, while in this state, he had attempted to commit suicide. When sober, he did not entertain, or at all events did not express these ideas of jealousy.

For some months before the murder, which occurred on the morning of Christmas Day, he drank very heavily. On Christmas Eve he had a violent quarrel with his wife: he stayed up all night, talking to himself, and occasionally beating his head against the wall. Early next morning his wife went to a neighbour's house to ask the time. The patient, who had got hold of a knife and had sharpened it, followed her and stabbed her to death. Immedi-

ately afterward he said, "It is all over last night's affair: I saw it with my own eyes: I did it deliberately over that." Thirty hours later he became mildly delirious and hallucinated; he talked about his wife's misconduct and about his own bodily condition, saying that his inside was taken out, that half of his penis was cut off.

Later on, when this state of agitation had subsided, he was able to give a coherent story of the murder: he said that his wife, who had been committing adultery for years, brought a man to the house on Christmas Eve; resenting the lover's presence, he went to bed, leaving the woman with her paramour; soon after, the door being partly open, he heard obscene conversation between them, and on looking out, saw them having connection in the presence of the children. After that he could not remember clearly what happened, but he thought that the couple left the house, and that he fell asleep. Next morning he followed his wife to the neighbour's house, intending, according to his story, merely to frighten her, but when he thought of what he had seen in the night, he lost control of himself and killed her.

This case is a compendium of the characteristics of alcoholic homicide in a mature phase of the intoxication, when the evidences of disorder have extended from the sphere of feeling and impulse to the sphere of thought. The morbid beliefs expressed by the patient in the delirious attack following the murder—the ideas of marital infidelity, of sexual mutilation, and of visceral disorder—form, in fact, a delusional triad which is almost distinctive of chronic alcoholism; while the suicidal and homicidal impulses, and the direction of the latter impulse to the person of the wife, are, as has been already pointed out, typical of the conduct disorders related to this condition. In instances where the issue of the impulse in the murderous act is delayed to a more advanced stage, the

accompanying delusions of jealousy become more fully and firmly organized, and the crime may then be carried out with a considerable degree of deliberation. One Broadmoor patient, for example, whose wife had left him on account of his drunken habits and his insane accusations against her chastity, inveigled her, under a pretext of repentance and reconciliation, to an isolated farm building, and, after reproaching her with her misconduct, proceeded to strangle her with a rope which he had brought prepared for the purpose with a noose. Another man, who shot at his wife and her solicitor in whose office he was meeting her to arrange a deed of separation, wrote detailed instructions on the previous day to the undertaker regarding his funeral when he should have "ended himself after doing justice on that infamous woman."

These cases illustrate the fact that homicide related to ideas of sexual jealousy is the most common and characteristic form of alcoholic crime with conscious motive ; and it may be added that, conversely, alcoholism is by far the most frequent cause of delusions of marital infidelity—at all events it is the most frequent cause of these delusions in cases that culminate in murder. So common, indeed, is this association that some observers have asserted that delusional jealousy is always of alcoholic origin. That assertion, of course, goes too far ; delusions of jealousy with homicidal tendencies are met with in many other morbid conditions ; they are, for example, as was pointed out in the preceding chapter, fairly frequent in senile insanity. It is true, however, that in comparison with the cases in which alcoholism is the main factor, the instances of homicidal jealousy of other causation are few in number. Moreover, in forms of mental disease which do not ordinarily present delusions of sexual jealousy in their clinical course, such

X

delusions may appear and may determine the direction of morbid impulse in cases where an alcoholic influence is operative to any considerable extent. This may be observed, for instance, in general paralysis when that disease develops in an alcoholic subject, or when there is a prolonged period of alcoholic excess in the initial stage of the malady ; some of the few recorded cases of murder by general paralytics from motives of jealousy show this association. And it is not very infrequent in the early period of dementia præcox.

This latter point is of sufficient interest to be worth illustrating by a concrete instance—

Obs. 13. T. K., aged 36, miner. Murdered his wife. The patient belonged to a very insane stock ; his father was weak-minded, as was also one of his brothers ; another brother was in an asylum ; a paternal uncle and a maternal cousin committed suicide. The patient himself was rather slow and backward at school, and was a very indifferent workman, but had not shown any definite indications of being mentally unsound up to a few months before the murder. He was of very intemperate habits, and was apt to be very violent, especially towards his wife, when he was drunk. After a particularly violent quarrel, in which he knocked her about badly, she obtained a separation order, but went back to live with him after a couple of months. He continued to ill-use her, and began to complain about her conduct, saying that she was going with the lodger and with other men, that she had tried to poison him by putting hair-lotion in his tea, that she had drugged his food to make him unconscious while she was committing adultery. He threatened that he would smash her neck if she continued to dope him. Two days before the murder, he had auditory hallucinations, the voices telling him, amongst other things, that he ought to cut open his leg

to get out something that had been introduced into his body.

On the day of the crime, the patient was alone with his wife in the kitchen ; a neighbour, hearing a scream, ran in, and found that the woman was lying on the floor with her skull battered in ; the patient meanwhile had rushed out of the house and gone to his brother's ; he told his brother what he had done, and then accosted a policeman, saying, " I've killed my wife ; I've done it this time, but I was driven to it ; I did it with a coal-rake." In prison, while awaiting trial, he repeated the delusions about his wife ; but, very soon after his admission to the asylum, they receded into the background ; he would still refer to them when questioned about his crime, for which he expressed no remorse, and which he treated, indeed, with a certain amount of levity, as rather an amusing exploit. In a short time he developed delusions of possession, said that some one was using his voice, that there was a man in his inside who ate all the food he swallowed, on account of which he refused his meals. He rapidly became more demented, with mannerisms and stereotyped movements, and had occasional impulsive outbursts, in which he would break windows and make sudden and violent attacks on attendants and fellow-patients, explaining these acts by attributing the blame to the victims, who " had put the strength into him," so that he could not help what he did.

In this case, the transitory character of the delusions of jealousy, and the rapidity with which they faded when he was cut off from liquor, may most reasonably be accounted for by ascribing them to the action of alcohol in the initial stage of a typical dementia præcox. Instances of this sort, where the early symptoms of a degenerative insanity have a temporary alcoholic colour-

ing, are fairly common, and have, no doubt, contributed to create the fallacious belief that such forms of mental disease may be due to alcoholism.

Now, when it is considered that in the great majority of cases of alcoholic homicide, whether of the purely automatic type or associated with more or less stable delusions, the victim is the wife or mistress of the murderer ; and further that in these cases there is a regular gradation from deliberate murder with fully developed delusions of marital infidelity, through instances where such delusions have been only fleetingly present in intermittent states of drunkenness, and so on to cases of murder in alcoholic automatism—when these facts are taken together, they suggest as a probable inference that the underlying morbid condition is very similar throughout the whole series, and that the organic disorders of chronic alcoholism tend not only to generate the homicidal impulse, but also to give to it a specifically sexual colouring and direction. The fact referred to above, that delusions of jealousy occasionally develop under the influence of alcohol in general paralysis and in dementia præcox, would obviously harmonize with this view. And we shall find further evidence in its support when we come to discuss the pathology of this chronic intoxication.

Homicidal jealousy, whether it be due, as it most usually is, to chronic alcoholism, or whether it be related to other morbid states, shows a remarkable degree of uniformity in its clinical characteristics ; and this fact is suggestive of a corresponding uniformity in its morbid organic basis. Thus there is ordinarily an initial phase of emotional irritability, probably with some increase of sexual desire and diminution of sexual power ; there then develop suspicions of marital misconduct, either general or in respect of some particular man ; confirmatory evidence of these suspicions is speedily forthcoming,

either in real trivial incidents interpreted in a delusional manner, or in definite hallucinations ; formal accusations, wearisome demands for a confession of guilt, and threats of violence, are accompanied by efforts to secure proof ; the suspected wife is watched, she is forcibly examined for signs of recent intercourse ; her linen is minutely scrutinized, her visits to the closet are supervised ; if her feet are cold at night, it is because she has been out meeting her lover ; if she sleeps soundly when she goes to bed, it is because she is exhausted by her amorous excesses during the day ; if her rest is broken it is because she is trying to keep awake for an assignation. And when this state of things has gone on for weeks or months, the final quarrel comes, probably after one or more separations and reunions, and the woman is murdered.

In alcoholic cases, as has been already mentioned, the suspicions and threats may for a time be expressed only in phases of actual drunkenness, and murder is often committed at this stage ; later on, when the delusions have become more established and persist in sober periods, the act may be done without any immediately preceding alcoholic excess, and may be deliberate. Delusions of drugging or poisoning usually accompany delusions of jealousy when chronic alcoholism is the causal condition ; they are less frequent, though fairly common, in the homicidal jealousy of the senile and the pre-senile.

In women the symptoms of insane jealousy are very similar ; but the condition does not lead so often to the murder of the suspected partner. More frequently it culminates in suicide, in the murder of the children, or occasionally, especially in alcoholic cases, in attempts to mutilate the husband's genital organs.

When delusions of jealousy are due to alcoholism, and when there is no complicating factor, such as premature senile degeneration, they almost always disappear

after some months of detention and enforced abstinence, and their morbid character is recognized by the patient ; in other cases they may persist, and, if the victim of the murderous attack has survived, the delusions may even undergo further elaboration and may be reinforced by confirmatory hallucinations of sight and hearing.

To complete the survey of alcoholic homicide, it remains to refer to murder in delirium tremens. This condition is a fairly well defined clinical disease form, and is, in fact, the alcoholic psychosis *par excellence*. It is a confusional insanity with profuse hallucinations, especially of sight, and occurs in subjects of chronic alcoholism, developing under the influence of secondary causes, whose nature is still undetermined, and subsiding usually after a duration of some days. In this disease murder may be committed under very much the same conditions as in cases of pathological drunkenness ; that is to say, it may result from a direct homicidal impulse, with or without an accompanying impulse to suicide, and there may be no memory of the act, and no idea of its motive. Very often, however, the violence has an apparent connection with the terrifying hallucinations which may beset the patient, so that in a state of panic fear he kills his victim under the impression that his own life is threatened by some human aggressor or by some monstrous or supernatural assailant. This is the sort of accident that may happen, as in several recorded instances, when a drunkard develops delirium tremens while locked up in a police cell with other prisoners.

Homicide is the most frequent, but it is by no means the only form of grave criminality related to chronic alcoholism. This condition plays an important part in the causation of certain sexual offences, especially the graver offence of defilement of children, and the minor offence of indecent exposure, or exhibitionism. These offences,

as we saw in the preceding chapter, are also frequently associated with senile degeneration ; and, as their clinical features are very much alike, whether they are committed by alcoholic or by senile offenders, it is not necessary to describe them further here, except to remark that in alcoholic cases there is a somewhat greater tendency for the sexual crime to be accompanied by murder, either as the result of morbid impulse or with a view to avoiding denunciation.

Arson and other forms of malicious destruction of property are also occasional crimes of the chronic alcoholic, resembling in their characteristics and the circumstances of their execution the similar offences of the imbecile and the paralytic.

One further point may be referred to, before passing on from the consideration of alcoholic crime in its clinical aspect. That is the frequency of false confessions of guilt by alcoholic subjects. Such confessions are often made by imbeciles and hysterics for the purpose of gaining notoriety, and the same motive may occasionally operate in the case of the drunkard. But in many instances the self-accusations of the alcoholic are of a quite different origin, and appear to be due to a realization in fancy of a project either consciously elaborated or in process of evolution in the subject's impulsive disposition. For example, a drunken carter, employed at the Docks, was sent to prison for disorderly conduct, and on admission gave a detailed account of the theft of some wagons of flour which he said he had stolen with the help of another man. A careful investigation by the police failed to discover any trace of such a theft having taken place, but the prisoner adhered to his statement with obvious conviction of its truth. Four days later he developed delirium tremens, and on recovery professed to have no recollection whatever of the story

which he had told. In a similar way, the impulsive crimes of the alcoholic seem sometimes to be foreshadowed by imaginary action in delirium or in dream states.

This completes our description of the clinical aspect of alcoholic crime. We have next to attempt an interpretation of the facts which we have passed in review, and for this purpose it is desirable to consider these facts in the light of the pathological evidence regarding alcoholism. The first point we have to note about the bodily disorders produced by this chronic intoxication is their generalized distribution throughout the economy. They may differ in different cases in the degree of their incidence on this or that particular system, but in all cases most of the systems are affected in some measure ; there is always a fairly widespread disorder of the bodily organs—a general organic decadence. Chronic alcoholism, as has been aptly said, is an anticipated and morbid old age. There are, however, certain seats of election, certain organic systems where the pathological effects of alcohol are commonly most marked, and of these the most important, the earliest and most constantly affected, are the nervous and digestive systems and the genital glands.

The most obtrusive and distinctive symptoms of chronic alcoholism are notoriously connected with the nervous system and the alimentary organs. Muscular tremor, cramp, insomnia, irritability of temper, failure of memory—all these indicate the disturbance of nervous function in the drunkard ; and, supervening on them, and constituting in some sort an exacerbation of them, there is the specifically alcoholic affection of the brain—delirium tremens. Again, the toxic action of alcohol, and of the secondary agencies to which alcoholic lesions open the way, is revealed, as regards the alimentary organs, by a cortège of symptoms ranging from common

dyspeptic troubles to the profound disorders of cirrhosis of the liver. So much for the effects of alcoholic excess on the nervous and digestive organs.

The lesions of the genital glands do not give rise to such direct and obvious symptoms; but the fact of their early and deep involvement in chronic alcoholism has been placed beyond dispute by the results of pathological and experimental research. It would appear, indeed, from the investigations of Bertholet,¹ which have been confirmed by Weichselbaum,² that atrophy of the essential glandular elements of the testes and the ovaries, is the most frequent and the most pronounced of the morbid changes found in the bodies of alcoholic subjects. And it has been shown by experiments on the rabbit that alterations of a closely similar character are induced in the genital glands of that animal by the continued administration of alcohol.

We have, then, in chronic alcoholism, on the one hand, a diseased condition of the nervous system, and particularly of the higher levels of that system, which subserve mental functions; and on the other hand, a generalized visceral disorder, affecting in a special degree the alimentary organs and the sexual glands. The nature and distribution of these morbid changes thus present a remarkable and suggestive correspondence with the character of the emotional and intellectual disorders in this chronic intoxication. It is a correspondence which we can most readily account for if we regard the mental symptoms of alcoholism as resulting from what Maudsley has described as "the special intelligence which the brain has of the disorder of the particular organ."³ On

¹ Bertholet, *L'influence de l'alcoolisme chronique sur les organes de l'homme*, Lausanne, 1913.

² Weichselbaum, in *Verhandl. der deutsch. pathol. Gesellschaft*, 1910.

³ Maudsley, *Pathology of Mind*, p. 152. London, 1895.

this hypothesis the reflection in affective and intellectual activity of the bodily disorders produced by chronic intoxication by alcohol, should show exactly what we find in that condition—a pessimistic and malignant emotional tone with suicidal and homicidal impulses, and with a specific colouring of morbid impulse and morbid thought in harmony with the special incidence of the poison on the digestive and sexual glands. The mental disorders of chronic alcoholics are thus the “psychic signature” of the morbid bodily state—in conduct, suicide, wife murder, the perverted sexual offences against children; in thought, the delusions of poisoning, of marital infidelity, of genital mutilation.

It will be observed that, according to the view here suggested, the relation between the morbid impulses and the morbid ideas which arise from this state of organic disorder—whether the state be due to alcoholism or to some other noxious agency—is not in reality, though it may frequently be in appearance, a logical relation. Ordinarily, no doubt, the group of symptoms characterized by delusions of jealousy, of poisoning, and of sexual injury or infection, is associated with homicidal impulses directed against the supposedly unfaithful wife; and then the delusions may seem, and are often said, to be the “cause” of the criminal act. In fact, however, the condition is quite clearly that of dependence on a common origin in the state of the organic life; we have seen evidence of this in the priority of morbid impulse over morbid thought in the evolution of this diseased condition. And we have further proof of it in the occasional instances in which the same delusional ideas are associated, not with wife murder, but with other crimes of like morbid origin, and notably with sexual outrages on children. As this is a point which, apart from its theoretical interest, has an obvious importance

in medico-legal practice, it is desirable to illustrate it by a concrete example.

Obs. 14. W. J. H., aged 41, ex-soldier, in civil life a fisherman. There was a history of alcoholism between the ages of 20 and 30, but the patient had been regarded as at all events relatively sober for many years before the crime ; there was nothing else of special note in his personal antecedents prior to war. Early in 1915, while serving on the Flanders front, he was blown up by the explosion of a shell, which hurled him some distance and knocked him silly. Either immediately, or within a very short time after this experience, he developed general tremor, which has persisted ever since. He spent the rest of his service either in hospital or on base duty—including a spell in Salonica, where he contracted malaria—till September, 1918, when he was invalided with the label “shell shock.” He had been twice married, having children by both wives ; his second wife died while he was on active service ; and soon after his return to his native town on demobilization, he married for the third time. Quite early in his honeymoon, he began to show indications of insane jealousy : he heard knockings on the wall, which he interpreted as signals made by his wife’s lovers ; a herpetic spot on his penis was proof that she had infected him with syphilis ; he found her feet cold in the middle of the night, showing that she had been out of bed with a paramour ; he forcibly examined her privates and imagined that he had discovered evidence of recent intercourse ; she would blow on his eyes, dope his tea and give him drugged cigarettes, so as to make him sleep heavily, while she went out with men. There was no doubt as to the genuineness of these delusions. He made repeated complaints to the police about the nocturnal annoyances of the imaginary lovers ; he took his wife to a doctor and had her examined, as

well as himself, for the presence of venereal disease ; he submitted samples of his food to a druggist for analysis.

Some three months before the crime, the patient took the girl he subsequently murdered for a tram ride into the country, left her there, and reported her absence to the police. She was found wandering in the fields, and told a story of having been enticed into a house and violated. This story was found to be wholly fictitious, and the girl then admitted to the police that her father had drilled her into saying it.

The patient's increasingly violent conduct ultimately compelled his wife to take refuge with her parents, leaving him in his home with the children of his second marriage, three girls. Some days later he was seen to go out of the house with one of these children, a girl of 13, returning alone a couple of hours after ; on the evening of that day, he went to the police station, and reported that she was missing and that he was uneasy about her, because she had previously stayed out all night, and he was afraid some man might have got hold of her. Search was made, and the child's body was found in a pool on the seashore ; she had been battered on the head and thrown into the water ; she had been recently outraged. When arrested, the patient, after some protestations of innocence, admitted the crime, and gave a clear and, probably in the main, a truthful account of it. He had made fairly intelligent efforts to get rid of incriminating evidence on his clothes and in the house, where the rape had been committed.

In this case the clinical picture was characteristic of the insane jealousy arising on a basis of organic disorder and reproducing the group of symptoms—the delusions of marital infidelity, of drugging, and of sexual infection—which are typically seen in chronic alcoholism. As to the cause of the morbid condition in this particular

instance, it is difficult to form any positive opinion ; it may have been due in part to the former intemperance of the patient, and it is also conceivable that the pathological changes underlying some forms of war neurosis may affect the genital glands very much as chronic alcoholism affects them ; it has been claimed by the Italian physiologist, Carlo Ceni,¹ that in dogs subjected to repeated cerebral concussion, the sexual glands present atrophic changes, apparently of somewhat similar character to those described by Bertholet and Weichselbaum as occurring in chronic intoxication by alcohol. However that may be, it is a legitimate inference from the clinical facts that, in this case, the sexual crime is to be regarded as a result of the same morbid condition which produced the characteristic delusional symptoms. The criminal act, though having no logical connection with the patient's delusions, was none the less an outcome of his insanity.

¹ Carlo Ceni in *Revista sper. di Freniatria*, 1914.

CHAPTER VI

CRIME IN MANIC-DEPRESSIVE INSANITY

In the preceding chapters we have dealt with the relation to crime of the three main varieties of organic dementia—general paralysis of the insane, senile insanity, and alcoholism. The mental diseases which we have next to examine from the same point of view—the psychoses proper—differ from these dementias in this among other characters, that the main factors of their causation are endogenous, and, in particular, hereditary ; they are disorders of an originally unstable brain, which becomes deranged in action of its own native default with, for the most part, relatively little co-operation of agencies from without. This innate abnormality of organization influences to a very great extent the character of the aberrations of mental function which these insanities present, whether in the sphere of conduct or of thought ; they are more varied and more complex in origin than are the impulsive and ideational derangements that accompany the deteriorations of the primarily valid brain, as in the organic dementias which we have so far had under review ; and they may be considered generally to be in a greater measure direct products of a faulty psychic activity.

On this account, indeed, they are sometimes asserted to be of purely psychogenic nature, and therefore to be accessible, solely or mainly, to psychological methods for their analysis and for their treatment. We are not con-

cerned here with the truth or error of this doctrine ; its interest for us is simply in the fact that such a doctrine can be plausibly maintained in regard to these psychoses, whereas it would hardly be suggested in the case, for example, of general paralysis. It is important to take note of this prominence of the psychogenic elements in the symptomatology, if not in the causation of the psychoses, for it has frequently a significant bearing on the character and direction of the criminality associated with them.

It has been already remarked that the attempts which have been made to classify these disorders into separate disease forms have not been conspicuously successful ; and, indeed, from the nature of the case they could hardly be expected to do more than provide a more or less provisional and arbitrary system for distributing into typical groups clinical phenomena which, despite their apparent diversity, may quite conceivably depend on morbid conditions of fundamentally similar nature. So far, the practical outcome of these attempts, as reflected in psychiatric opinion at the present time, has been the differentiation of a few main types of psychosis, distinctive in character in extreme examples of the several types, but grading into one another by intermediate and mixed instances.

For the purposes of our inquiry, it will be convenient to recognize three clinical types established after this fashion, these types being distinguished, in rough correspondence with the conceptions and nomenclature of Kraepelin, as manic-depressive insanity, dementia præcox, and systematized delusional insanity. It is a matter of discussion, which hardly comes within the scope of this study, how far this clinical grouping corresponds to differences in pathological nature, in particular, how far manic-depressive insanity on the one side, and a considerable number of the cases of systematized delusional

insanity on the other, are really to be differentiated from the large and vaguely defined category of dementia præcox. It has been shown by the brilliant researches of Sir Frederick Mott ¹ that in this latter disease form, the psychic degeneration is the result of an original vital inadequacy, revealed in regressive changes in the brain and in the reproductive organs. And from his further investigations Mott has been led to suggest that a similar origin must be assigned to psychoses which are regarded clinically as outside the dementia præcox group. On this point he observes in a recent publication: "In those forms of psychoses in which recovery takes place—for example, confusional insanity or exhaustion psychosis, benign stupor, periodic insanity, or manic-depressive insanity—we may assume there is a suspension of neuron function at the highest psychic level; but all these conditions I have found may end in a terminal dementia, in which the changes in the reproductive organs and in the brain do not differ from those met with in the primary dementia of adolescence, the dementia indicative of a suppression of function. In the primary dementias, naturally, the symptoms may be partially due to a suspension, and partially to a suppression of function, and I would explain partial remission of symptoms by a partial restoration of function in neurones in which the nuclear change was either not present or not advanced." ²

It is desirable to lay stress on the conclusions of this distinguished authority in order to emphasize the limitations and the purely provisional character of schemes of psychiatric classification, whose only value is in their practical convenience for purposes of clinical description. The risk of fallacy involved in attributing to them any

¹ Mott, *Archives of Neurology*, vol. 3, 1922.

² Mott, *Journal of Mental Science*, 1922.

greater significance is, no doubt, of comparatively little account in relation to the aspect of insanity with which we are here concerned ; but it is none the less advisable to keep well in mind, even in this connection, that these so-called diseases are merely clinical groups, and that their differences in criminal proclivity are related for the most part to secondary and symptomatic peculiarities, and not to any radical divergence in the character of their morbid cerebral basis. It is with this explicit reservation that we shall here adopt the rough classification indicated above.

In the present chapter we shall examine the relation to criminality of the first of these large clinical groups—the manic-depressive psychosis—considering also, in connection with the melancholic phase of that disease, the exhaustion psychoses, which, so far at all events as their bearing on criminal conduct is concerned, are of closely similar import.

Manic-depressive insanity, according to the conception of Kraepelin, comprises a large number of states of mental disorder which have been regarded in the past, and are still considered by some contemporary writers, as distinct and separate forms of disease. Thus “it includes on the one hand the whole domain of so-called periodic and circular insanity, on the other hand simple mania, the greater part of the morbid states termed melancholia, and also a not inconsiderable number of cases of confusional insanity,” as well as “certain slight colourings of mood, some of them periodic, some of them continuously morbid.”¹ This comprehensive view rests very largely on the fact, established by clinical experience, that all these morbid forms not only pass from one into the other without recognizable boundaries,

¹ Kraepelin, *Lehrbuch der Psychiatrie*, Band III, Th. II, p. 1183, 8th ed. Berlin, 1913.

but may even replace one another in one and the same case. And it is further supported by the observation that, despite their superficial differences, they all share a common tendency to recurrence and a common absence of tendency to permanent mental enfeeblement.

Moreover, the investigation of the family histories of manic-depressive patients has given some ground for concluding that these several clinical varieties are equivalent in the stock, so that cases of mania, of melancholia, and of periodic insanity, may appear in the same or in different generations of one family. Accepting provisionally this theoretical view, we may describe the characteristic features of manic-depressive insanity by saying that this disorder is manifested by attacks of maniacal excitement or by attacks of melancholic depression, of varying degrees of intensity, and occurring either as isolated episodes in the patient's life, or in more or less frequent and more or less regular recurrence; that the successive attacks may be marked by the same emotional tone, or may be at one time maniacal and at another melancholic, occasionally in regular alternation, while in some instances there may be a mixture of the opposed moods in the same attacks; that it does not tend to dementia, but that after each attack, whether manic or melancholic in type, there is usually, at all events until late in life, a return to the pre-existing mental condition. That condition, however, is frequently by no means normal, and it is of special interest to us here to note that its abnormality is very apt to be manifest in feeling and conduct. Indeed, in many, if not in most instances of the psychosis, the successive attacks which occur in the career of a manic-depressive patient may be regarded as representing merely extreme oscillations in a permanently unstable and fluctuating temperament, which, apart from any such marked exacerbations, is itself not

infrequently the source of eccentric or reprehensible acts.

This constitutional disposition, which may be met with in persons of manic-depressive stock, even when they have never suffered from actual mental derangement, has been qualified by Kretschmer ¹ as the "circular" temperament, in contrast to the "schizoid" temperament which characterizes the potential victims of dementia præcox.

From the point of view of its relation to crime, we have to distinguish between the manic and the depressive phases of this disease, whether revealed in fully developed attacks of obvious insanity or merely in minor fluctuations of mood. Manic excitement is very rarely associated with grave criminality, but it often leads, especially in its lighter forms, where it may be shown only by some degree of morbid emotional exaltation, to various petty offences, such as fraud, theft, or trivial assaults. For example, one patient, in whom the disease was of the complete circular variety, and who, in his melancholic state, was ultra-scrupulous, deeply religious, and at times suicidal, was wont to pass most of each succeeding manic period in prison, serving short sentences for travelling without a ticket, bilking and assaulting cabmen, and brawling in public. Not infrequently, swindlers who are considered to be suffering from so-called moral insanity are in reality mildly exalted manic-depressives. The sexual excitement, which is a common accompaniment of this phase, is more usually satisfied in legal ways, but may sometimes lead to indecent assault or to rape.

On the other hand, as homicidal impulse is alien to the mood of exaltation, murder is very rare in manic excitement. Exceptionally, however, grave homicidal crimes may be committed by exalted manic-depressives when their rash and reckless temper is provoked by some

¹ Kretschmer, *Körperbau und Character*, Berlin, 1922.

real or imaginary grievance, arising, for example, in the course of litigation. In cases of this sort there may be a semblance of premeditation about the crime, which, together with the evidence of motive, may tend to obscure the morbid character and origin of the act, especially if the disease has been manifested chiefly by a more or less continuous state of mild exaltation of temper with eccentricity of conduct, but without obtrusive disorder of thought. The attitude of the murderer after the act will often strengthen the suspicion of sanity, for it is somewhat characteristic of this affection in its minor manic form that the patient, like the ordinary criminal, is usually profuse in efforts to explain and extenuate his misconduct.

In one case, for example, a patient of typical hypomanic temperament, who came of a neuropathic and insane stock, and had himself been noted all his life for his erratic and irresponsible behaviour, had a dispute with his landlord about the condition of a shop he had rented ; he went by appointment to the man's office, and shot him dead. Despite the fact that two shots had been fired, one of them at very close quarters, the patient maintained, with every appearance of conviction, that the affair was a mere accident, that he had only meant to frighten his victim by firing the revolver, as he had often done when a bit excited, and that the man had stupidly got in the way.

In some instances, homicidal acts are committed, as are also suicidal attempts, in brief phases of depression occurring in the course or at the onset of a predominantly manic attack ; and in cases of this sort, when the depression has decreased or has been replaced by a relatively buoyant mood, the patients will frequently show a tendency to self-exculpation which seems to have some analogy with the attitude of the manic murderers referred

to above. Thus, if, as is often the case, the crime was committed in a more or less confusional state, the patient, when mentally clearer, may refuse to believe in the reality of the fact, or may have consolatory visions of the happier condition of the victim. One woman, for example, who had gone through an attack of melancholia ten years previously, became somewhat restless and depressed, and threw her three children into a canal. After the crime, though she had a vague idea that she had had some fearful experiences, she insisted that the children were alive and well ; she then regained a fairly clear memory of the affair, but on passing into a severe manic phase some weeks later, she reverted to her belief that the children were not dead. The following observation exhibits this tendency in a manic-depressive attack of the mixed type :—

Obs. 15. L. T., aged 52, widow. Murdered her 9-year-old daughter, and attempted suicide. Patient had been a widow for several years, had got over the climacteric, and had some indications of early arterio-sclerosis. Beyond some degree of restlessness, with alternations of moodiness and coquetry, she had not shown any signs of mental change prior to the crime. One day she came to the door of the little shop which she kept, and called her daughter, who was playing with a companion, into the house. She was discovered shortly afterwards in a back room with her throat cut, kneeling beside the dead body of the child : she was confused, incoherent in speech, and emotionally depressed. At the police station she said, in answer to repeated questions, that she remembered “cutting the child’s head off,” had felt that “she had to do it,” that, after killing the child, she had tried to kill herself. The confusion cleared up gradually, and the patient became very melancholic, expressed delusions of unworthiness, dwelt on the enormity of her crime,

and said, "I wish I had left her alone, and done it to myself, but I thought she'd be better dead." Later on she began to show signs of increasing restlessness and irritability, and the mood of depression was occasionally lightened by flashes of liveliness. She would then say, "The one as I cut the head off of is living now—something comes and tells me she isn't dead." Subsequently she became deeply melancholic, with refusal of food.

The general characteristics of murder in purely or predominantly melancholic cases will be sufficiently illustrated by the two following observations:—

Obs. 16. W. L., aged 55, tradesman. Murdered his wife. There was no definite evidence of insane taint in the patient's family history, but some relatives on one side were said to have been notoriously excitable and eccentric. The patient himself had been a hard-working, intelligent, and active man of business, and had acquired a good financial and social position in his native town. He had enjoyed excellent health till about eighteen months before the murder, when he began to show signs of mental disorder, becoming emotionally depressed and anxious, sleeping badly, and complaining of imaginary ailments. This condition became gradually worse, and his hypochondriacal ideas took on a clearly delusional character—he thought that his bowels were stopped up, that his circulation had ceased, that a hair lotion which he had used had soaked in and rotted his brain. A sudden attack on his wife led to his certification and removal to an asylum, where he improved rapidly. After nine months' detention, he was liberated on trial, and went to live with relations in a town at some distance from his home. He was at first in charge of an attendant, but, as he seemed to be going on well, this precaution was discontinued after a few weeks. A fortnight later, he left the house of his relatives, made his way to his

own home, and cut his wife's throat with a razor. When the police came on the scene of the tragedy, the patient, who was quite calm and collected, told them what he had done, and handed over the weapon he had used. He said that he had come home for the purpose of killing his wife because he knew that he was dying himself, and he did not wish to leave her to face the world alone. In prison, and afterwards in the asylum, he was deeply melancholic, with ideas of spiritual unworthiness and profuse and fantastic hypochondriacal delusions. These symptoms persisted with little alteration for several years, and then the patient began slowly to improve, ultimately regaining a fairly normal state, though still showing an exaggerated preoccupation about his material and spiritual health and comfort, and a querulous and egoistic temper. After some twelve years' detention, he was well enough to be released to the care of a religious society, and got along very well for a couple of years, when he again became depressed and suicidal, and had a recurrence of his former hypochondriacal delusions. This morbid condition persisted to extreme old age, but without any enfeeblement of his very acute intellect.

It will be observed that in this last case there was throughout a marked predominance of the hypochondriacal element in the patient's morbid emotional state ; and it may be noted that this is relatively frequent in melancholic murder, and may possibly suggest that the delusional emphasis in these cases on the visceral condition indicates a greater degree of disorder of organic function from which the homicidal impulse would be more apt to develop.

In most cases of murder in manic-depressive insanity, as in the instances quoted above, the homicidal tendency is associated with a tendency to suicide, and frequently seems, indeed, to be a transformation or extension of

the latter impulse. A similar relation between the two impulses is also very common, as was pointed out in the preceding chapters, in senility and in alcoholism ; but in these latter conditions it appears to be of a somewhat different character to what is observed in melancholia. The distinction may be roughly expressed by saying that the destructive impulse in the senile and the alcoholic is, in some sort, a protest, in the melancholic it is an acceptance, so that in the former the impulse is homicidal-suicidal, in the latter it is suicidal-homicidal. Thus it is rare in melancholia for the crime to have any element of malignancy about it ; the suicidal melancholic who kills his wife, usually kills her as being, so to speak, a sharer in his own personality, and when he rationalizes his impulses, whether before or after the act, he explains his conduct by saying that he could not leave one he loved so much to face the world alone, that his motive was to save his victim from suffering, to protect her against some more terrible affliction which threatened them jointly. His emotional attitude thus differs widely from the attitude of the senile or the alcoholic murderer ; the senile generally, the alcoholic nearly always, kill from morbid hate ; there is no flavour of altruism in their conduct, the crime is an act of vindictiveness, of revenge for imaginary wrongs.

There are, of course, gradations in this contrast of attitudes ; the melancholic may have a vague sense of persecutory grievance mingled with his mood of depression, and the alcoholic murderer may feel, or may profess that he feels, more sorrow than anger when he slays his supposedly unfaithful wife. But in a broad view of the facts, the rule holds good that melancholic homicide does not present the note of malevolence which ordinarily characterizes the impulses in states of depression that arise from persistently morbid conditions of the organic

life. Even when, as occasionally happens, a melancholic commits murder in order to be hanged, and so to achieve a suicidal purpose without offence to his religious scruples, he has no feeling of ill-will towards his victim, but makes his selection quite at random, and kills probably some casual passer-by whom he has never seen before.

Whatever be the source of this emotional difference—whether it be due to some dissimilarity in the extent or nature of the underlying organic disorder in the two opposed types of disease, or to some larger admixture of a purely psychogenic element in melancholia—the difference is in itself of some interest in relation to crime, as indicating the comparatively minor degree of anti-social significance that attaches to melancholia.

What has been said above with regard to homicidal crime in the melancholic forms or phases of manic-depressive insanity applies equally to the cases of murder associated with the exhaustion psychoses, which find their most characteristic and most frequent expression in the murder of their children by nursing mothers. Many of these cases are, in fact, instances of the manic-depressive psychosis, in which the stresses of child-birth and lactation seem to act as the exciting cause of a manic or melancholic attack, just as these same influences may apparently determine the development in predisposed subjects of dementia præcox, or, in rarer instances, of general paralysis. Whatever be their ultimate course—whether they show the clinical characters and the tendency to recurrence which would connect them with the manic-depressive type, or whether they pass into the peculiar enfeeblement of dementia præcox, or whether, as in most instances, they make a rapid, complete, and apparently lasting recovery—these cases of lactational child-murder form, in their proximate causes and in their earlier symptoms, a fairly homogeneous group, in

which the phenomena of morbid impulse are displayed in a peculiarly clear and instructive way. Their clinical features will be best illustrated by some concrete instances.

Obs. 17. R. C., aged 31, married woman. Murdered her 3-months-old child by cutting its throat with a razor. There was nothing of note in the ascertained facts regarding the patient's family history, and she had herself enjoyed good health, bodily and mental, prior to her marriage at the age of 28. She was happy in her married life, and had looked forward eagerly to having children. During her pregnancy she worried a good deal about taking the right sort of food "to strengthen the baby," and was very anxious lest she should be unable to suckle the infant. Confinement was difficult, and required the use of instruments, but convalescence seemed to be fairly rapid, and the milk came on plentifully. Soon after beginning to nurse, however, the patient began to feel depressed and to suffer from headache and insomnia. She kept "wondering about everything she did, whether it was right and whether she did it now as well as she used to do it"; worried, too, as to whether her husband did not think she ought to do better. Wanted to be dead, and had a longing to kill herself; had a recurring sense of "something dreadful," of "feelings that came against her will." These feelings were at first quite vague, but about five weeks before the tragedy were definitely suicidal for a time, leading her to ask her husband not to leave her alone. She went to stay with her mother for a change, and seemed to get better. She returned to her home, and went on with her domestic duties, though still feeling worried and apprehensive. The milk was occasionally irregular, but was abundant on the day of the murder. On that day, after breakfast, she gave the baby the breast and took it upstairs to put it to bed. At this moment an "awful feeling" came

over her, she put the child down on the bed, and remembered nothing more until she saw that the child's throat was cut. She had a vague recollection of taking the razor from the drawer, but could not say whether this was before or after she had put the baby on the bed. She had no recollection of any imaginary motive for the act, and the impulse was not associated with any hallucination. She felt clearer and "lighter" immediately afterwards. The emotional depression passed off within a short period, and the patient made an uninterrupted recovery. After her return to her home she had another child, without any recurrence of nervous trouble.

Obs. 18. E. M., aged 23, married woman. Murdered her 11-months-old child by cutting its throat, and attempted suicide by the same method. Very little information was obtainable regarding family history; the patient herself was said to have been always "nervous," and from about 10 years of age suffered from occasional "faints," apparently of hysterical character. Married at age of 20, she nursed her first child till it was 12 months old, and towards the end of that time became very depressed and miserable, and suffered much from headache. When nursing the second baby, born two years later, she had a recurrence of the same symptoms, but this time in a more severe form and beginning earlier. She found it increasingly difficult to get through her household work; noticed that her memory was very weak, so that she could not remember what she should buy when she went to shop; had very severe headaches, broken sleep, and terrifying dreams; became jealous and irritable, and had doubts of her husband's affection for her. These symptoms continued up to the time of the murder.

The crime was committed in the afternoon, and the patient was able to give a clear account of her move-

ments during the earlier part of the day. Recollected coming in with the children, sending out the elder boy to play, suckling the baby, and taking it upstairs, with what object she did not know. From that moment, she said, her mind was a blank until she found herself in bed with her throat bandaged. It appeared from the evidence that she spoke to the policeman who was fetched when the tragedy was discovered, and that she said to him, "I cut baby's throat first and then my own." She was rambling and incoherent. She professed to have no memory of this conversation, but after some weeks, said she had a vague recollection of seeing and speaking to the officer. Though she had felt extremely depressed and miserable, she was positive that she had never had any conscious impulse to suicide, and had never had an idea of hurting the baby. After remaining dull and apathetic for some weeks, she gradually improved, showed normal emotion in regard to the death of the child, and recognized that the jealous ideas she had entertained were morbid. Recovery was uninterrupted, and she continued in good mental health when she returned to her home, where she died of pneumonia some years later.

In the majority of these child-murders there is, as in the second of the above-cited observations, a more or less complete blankness of memory for the crime, and frequently for a variable period preceding and following it. In other cases there is a clear recollection of the sudden emergence of the impulse and of its issue in the act without any consciousness of motive, so that the patient seems, as it were, to be the helpless spectator of her own insane conduct; this condition is illustrated in Observation 17. And finally, when the melancholic state has been of rather longer duration, there may be a development of relevant delusional ideas, and the

patient will then explain the crime by her belief that the child was dying of some painful disease, or would grow up deformed or morally perverted, or that it had been changed to a devil, or that, for some other reason, it was better that it should not live. Intermediate cases connect these several types so that they form one uninterrupted series, in which the primary and constant feature is the morbid impulse to the annihilation of the self and the offspring.

In some of these cases, as, for example, in Observation 18, the patient may show, by statements made immediately after the murder, that she is to a certain extent aware of what she has done, but may later on profess an entire inability to recall to memory either the act or her own remarks concerning it. This may be observed in instances where it is difficult to imagine that there can be any motive for deliberate deceit, and the same attitude is frequently maintained long after any such motive, had it ever existed, must have ceased to be operative. It is reasonable, therefore, to assume that this amnesia is genuine, and the most probable explanation of it would seem to be that it results from the unconscious repression of the painful memory of the crime. Possibly the same mechanism is accountable for the amnesia in other cases also of this variety of murder. Not infrequently, the loss of memory, whether complete or partial, is only temporary, and the patient may suddenly or gradually regain the power of recalling the episode in all its details.

In some rare instances the repressed memory, in the process of revival, undergoes a perversion, and a pseudo-memory of the crime is evolved in a form to exculpate the patient. In one such case, for example, a woman, who came of a very insane stock, and who herself showed characteristic indications of a highly suggestible and

hysterical temperament, murdered her 10-months-old child in a confusional paroxysm. She was found immediately after the act in a state of wild excitement, from which she passed into a semi-stuporose condition, lasting for about a fortnight. On emerging from this phase, she could remember nothing of the crime or of the period which had elapsed since its occurrence. Some six weeks later, she suddenly became emotional on waking up in the morning, and said that her memory had returned ; she now gave a detailed account of the affair, but asserted that it was her husband who had killed the infant. He was the only other person in the house at the time of the tragedy, all the particulars of which she had heard at her trial. The patient maintained this belief quite firmly for some months, but then came gradually to recognize its inherent improbability, and eventually admitted that she could not be sure whether she might not have imagined the story. The romance had apparently been evolved subconsciously to transfer to her husband the guilt of the act, the painful memory of which had been repressed during the period of amnesia. Her responses to association tests gave evidence of a very marked tendency to emotional repressions.

CHAPTER VII

CRIME IN DEMENTIA PRÆCOX

Dementia præcox is the clinical label which has been attached by Kraepelin to a very comprehensive group of cases of mental disorder, characterized, as the name implies, by a tendency to permanent and relatively early failure of psychic function. In the large majority of instances the initial symptoms of the affection appear in the period of adolescence and early manhood, sometimes after exposure to noxious agencies of various kinds, but more frequently without any antecedent experience of an exceptional character to which it is possible to attribute a real causal influence. From this fact, and from the notable tendency of the disease to develop in stocks in which a constitutional instability is shown by the occurrence of other cases of mental disorder, commonly of the same type, it is reasonable to conjecture that dementia præcox is due in the main to an original inferiority of organization. The recent work of Sir Frederick Mott has furnished positive proof of this hypothesis, and has demonstrated the nature of the morbid predisposition which the theory assumes.

Mott ¹ has shown that this primary degenerative insanity is constantly related to pathological changes in the latest developed layers of the cerebral cortex, indicative of "an inherent germinal narrow physiological margin of functional capacity of the brain," by reason

¹ Mott, *op. cit.*

of which mental disorder is readily induced by stresses—physiological, psychological, and pathological — which would be borne with impunity by the normally constituted individual. The coincident regressive changes in the genital glands point to this cerebral degeneration being a manifestation of a general inborn deficiency of vital energy.

The symptoms which attend this process of mental degeneration are extremely varied and complex, so that the clinical picture shows very great diversity in different cases, and in the same case at different times. Beneath the superficial multiformity, however, there may usually be discovered, more clearly in some instances and less clearly in others, certain fundamental traits, of which the most characteristic is a peculiar disintegration of the psychic unity, a loss of co-ordination between the different modes of mental activity. Thus the morbid manifestations in thought, feeling, and conduct will very often appear to be to a marked degree disconnected and discordant; delusional ideas are expressed which seem entirely independent of, and frequently in striking contradiction with, the accompanying mood; and similarly the patient's actions will show a complete lack of harmony with his emotions and his thoughts. This autonomy of function has an important bearing on the character of the conduct disorders of dementia præcox, and explains in large part why that disease is so often related to serious criminality.

As Kraepelin has emphasized in his clinical description of the psychosis, the failure of functional co-ordination isolates the will from the other conscious activities, so that "very sudden impulses, not explicable even to the patient himself, interrupt the inner connection of psychic events."¹ When, as frequently happens, these sudden

¹ Kraepelin, *op. cit.* 954

and uncontrollable impulses are aggressive and destructive in direction, they may obviously issue in criminal acts of extreme gravity. And this is, in fact, the explanation of the majority of the crimes, especially the homicidal crimes, committed by patients suffering from dementia præcox.

The tendency to abrupt and irrelevant action characterizes this form of insanity in all its stages, persisting even in states of advanced dementia, where the seemingly mindless and inert patient may startle his guardians by some sudden and unprovoked act of violence or by an impulsive attempt to commit suicide. In relation to criminal conduct it is a point of special importance that this morbid impulsiveness is often a very early episode in the disease. A youth who may have shown no previous indications of mental disorder, or at most nothing more remarkable than some disposition to moodiness and solitary habits, will suddenly commit a murder for which he will assign no motive, or else some motive of a patently trivial and inadequate nature. In such a case, beyond the character and circumstances of the act, there may for a time be no grounds for attributing the crime to mental disease; the murderer may seem to be of normal intelligence and affectivity, and if he professes to have had a reason for his deed, as, for example, some morbid religious notion, he may be readily brought to admit that he was in error and may express contrition and remorse. After a longer or shorter period of such apparent sanity, signs of mental derangement develop suddenly or gradually, and it becomes evident that the crime was an initial symptom of dementia præcox. The following case is an illustrative instance:—

Obs. 19. A. L., aged 18, iron-worker. Murdered his sister by battering in her head with a hammer. Patient had a family history of insanity on both sides: his mother

committed suicide. There was nothing of special note in his personal history, except that as a boy he was of rather solitary habits, not associating much with his school-mates, and taking little part in their amusements. He did fairly well at school, leaving in the 7th Standard in his fourteenth year. After some casual jobs as an errand-boy, he started work as a blacksmith's striker, showing average aptitude in learning. About puberty he became addicted to masturbation, and developed an exaggerated religious emotionalism, becoming an assiduous Bible-reader, and devoting much attention to his own and his sister's spiritual health. Except for these pietistic tendencies, there was nothing noticeably abnormal in his conduct or demeanour up to the time of the murder. On the evening of the crime he invited his sister to go for a walk with him, and when they were in a secluded lane, he suddenly struck her from behind with a hammer which he had brought with him for the purpose. After the murder he went to the police station and said, "I have come to surrender. I have murdered my sister. I have done it for love of her. I did it with a hammer." According to the account which he subsequently gave, he had been worried because his sister, to whom he was greatly attached, was about to enter a business-house as a typist. He thought that this career would expose her to constant temptation, and he therefore killed her in order to preserve her purity. He did not insist very strongly on this explanation of his conduct, and was easily persuaded that it was absurdly inadequate and that he had done wrong. His memory of the incidents of the murder was intact, and he described the act in all its details with the lucidity and accuracy of a detached observer and without any perceptible trace of emotion.

For some six months after the crime, the patient showed

no signs of mental disorder ; he talked and acted in a quite rational manner, associated freely with his fellow-patients, and was a useful worker. Then he began to give indications of a morbid religious and sexual emotionalism, spent the bulk of his time in devotional exercises, and sent proposals of marriage to a girl who was an entire stranger to him. From this point his mental disorder made rapid progress : he refused to eat, announced that he was Jesus Christ, that he had been mystically married to his fancied inamorata ; that he was the Home Secretary ; he had frequent impulsive outbursts in which he destroyed his clothing, broke windows, and assaulted patients and attendants. Eventually he passed into a state of pronounced dementia, with occasional phases of excitement and impulsive violence.

It will be noted that in this case the patient alleged a conscious motive for his crime, though the halting manner in which he offered his explanation, and the promptitude with which he acquiesced in the suggestion of its absurdity, showed clearly enough that it was merely a very feeble effort to rationalize his morbid impulse. Later on, while he was still accessible to questioning, he made no similar effort to account for his sudden outbursts of violence, but would say that he could not explain his conduct, that he felt he "had to do it." This is much the more usual attitude of dementia præcox patients when they are able to discuss their criminal conduct ; though they may be, and usually are, able to recall quite clearly the details of the crime, they profess to be entirely at a loss to give any motive for committing it ; they are aware only of the impulse as a competing force, and look on as helpless spectators at the perpetration of the act which it inspires. The following observation is an instance of this development of morbid impulse with lucid consciousness :—

Obs. 20. A. H., aged 20. Murdered a boy—a stranger

to him. Patient, who was the son of well-to-do parents, was educated at a private school, where he was considered to be very dull and eccentric, and was noted for his solitary habits and for his lack of interest in boyish pursuits. On leaving school, he showed an increasing incapacity of application, was moody and reserved, quarrelled with his relatives, and ran away from home on two or three occasions. As his mental condition did not improve, his parents, some fifteen months before the murder, sent him to live and work with a farmer. He got along there pretty well, but was observed to be flighty and very changeable in mood, and showed a morbid preoccupation with religious matters. On the morning of the murder, he left the farm-house at an early hour, and late in the afternoon walked into a village some miles distant, where he asked his way to the police station, saying that he had come to give himself up for "killing a human being—a poor boy in a cornfield keeping birds"; that he had killed him with a stick and cut his throat with his pocket-knife; that he did not know what he did it for—he was obliged to do it; that he had the idea for about a week; that he had met two or three people on the road, and could scarcely forbear attacking them. He took the police to the scene of the murder, where the body of the boy was found with the throat cut and severe bludgeon wounds on the head. The patient adhered to this account of the murder at his trial and throughout his detention in Broadmoor, where he lived for many years in a state of mild dementia, apathetic and reserved in manner, occupying himself in gardening, and in such pretentious pursuits as the study of Hebrew.

In this case there was some reason for suspecting, though the patient did not admit it, that the idea of the murder may have been suggested by newspaper accounts

of a crime, very similar in character, which had attracted a good deal of attention a few months previously. It would, of course, be quite consonant with the psychogenic origin of many of the morbid symptoms of thought and action which develop on the basis of mental deterioration in dementia præcox, that a casual influence of this sort might play some part in determining the character and direction of impulse in that disease. And, in fact, instances which may be susceptible of such a mode of interpretation are not infrequent in cases of murder by dementia præcox patients, as in the following observation :—

Obs. 21. G. P., aged 21, miner. Murdered his fiancée by shooting her. The family history, which was, however, very incomplete, did not show any definite evidence of insane taint. The patient himself appeared to be normal in childhood and during his school years. At the onset of puberty, he exhibited a rather exaggerated degree of adolescent instability, and his physical development was irregular. From that period he began to show increasing oddities of manner and disposition; he was moody and solitary, was morbidly preoccupied about his health, would take up hobbies with excessive zeal and would abruptly drop them, remaining constant only to an interest in fire-arms, of which he kept quite an arsenal.

Some months before the crime, his peculiarities of manner became more marked; he slept badly, was frequently depressed, talked of suicide, complained of anomalous sensations in the head, and of failure of memory, and was often confused and rambling in his conversation; on one occasion, while at work, he had what was described as a fit. He had been courting the girl he murdered for about a year and a half, and the final arrangements were being made for the marriage,

which had the full approval of the parents on both sides. Four days before the murder, the patient, while at supper in the house of his fiancée, took from his pocket a newspaper with an illustration of a young man shooting his sweetheart, and showed it to the girl, asking her what she thought of it, and laughing boisterously at her comments on the affair.

On the day of the crime he accompanied her on a shopping expedition, after which they went together to the patient's home ; a few minutes afterwards, he shot the girl through the heart, and, as she was lying on the ground, fired another bullet from another pistol into her mouth ; he then concealed one of the weapons under a sofa, placed the other on the mantelpiece, and left the house. The following day he was found locked in the privy in a garden a few miles from the scene of the murder. He made no resistance to arrest, was cool and unconcerned, and, when charged with the crime, merely replied, " Yes, very well."

He maintained the same attitude of detachment and indifference while awaiting trial and after his reception into the asylum, showing no trace of emotion with regard to the crime, which he remembered quite clearly, but for which he said that he could assign no motive, except that " the idea came to him." He passed in a short time into a condition of colourless dementia, with occasional phases of mild excitement, in which he expressed vague persecutory and hypochondriacal ideas. The interest which this patient showed in the picture of a crime so closely resembling in detail the murder which he was to commit a few days later seems to warrant the conjecture that his act was partly due to suggestion ; and the peculiar circumstances of the act—the superfluous repetition of the shooting, and the use of a separate weapon for the purpose—would accord with this view.

The clear recognition of the emergence of the homicidal impulse as independent of, and irrelevant to, the rest of the conscious personality, which is notable in the preceding observation, is frequent in dementia præcox, even when there is a more general and active derangement of mind, as in the following observation :—

Obs. 22. F. W., 26 years of age, labourer. Murdered his mother by cutting her throat.

Patient's father committed suicide, and there was a history of insanity in relatives on the paternal side. There was nothing of special note in patient's childhood except enuresis persisting till about 10 years of age. He did very well at school. From the age of 14, and probably earlier, he was a confirmed masturbator.

Symptoms of mental disorder began to appear about two years before the murder while patient was working as a labourer in a Government dockyard. During the war he obtained exemption from military service on account of the nature of his occupation and by pleading conscientious objection, reconciling his pacifist principles with the character of his work by giving a personal application to something he had read in naval orders about "being prepared for action, but not going into action without direct express direction from higher authority." Some months before the crime he became increasingly solitary and introspective, resorted to religious and ascetic practices, and exercised himself particularly in what he termed "discipline for the repression of fear." He began to find a symbolic sense in trivial incidents. He had occasional fugues.

About ten days prior to the murder more active symptoms of disorder appeared; he felt himself to be what he described as more and more "mixed up," and had various anomalous sensations in the head and body, culminating in a sudden attack of terror, which led him

to take refuge one night in the police station. The evening following this experience an "interior voice or feeling" at the back of his head said to him, "Go and kill someone." Later on another voice or feeling said, "Jump from the rocks and we will save you." He jumped into the sea accordingly, but was rescued and charged with attempting suicide. After a week's detention in prison, during which he felt more tranquil and was able to sleep, but had fantastic dreams, he was handed over to the care of his family. On the evening of his return he went with some friends to the theatre, and while there had a recurrence of the "mixed-up" feeling and the fear. He had also a sensation, which he had already experienced, of being as it were in an invisible cage and being pulled upwards and downwards, of being in a great glass tube with the upper half of his body being drawn up and the lower down. In the night this sensation disappeared, and he had a sudden feeling of deadly cold, followed by severe diarrhœa. The voice or feeling at the back of the head now kept saying, "Kill your mother and save your life"; he went to his brother's room, took his razor, and went to his mother's bedside, but the impulse failed, and he lay down again in his bed, and later on replaced the razor where he had found it. Early next morning his mother brought a cup of tea to his room, and patient went downstairs, got the razor, came up behind her and cut her throat back to the spine. This time there was no voice; he knew what he was going to do, but not why he was doing it.

When in custody shortly after the murder, he resumed masturbation—which he had given up altogether for several weeks previously—and practised it frantically, in spite of the warning voice, "Save the seed, it's your only chance." He gave the same lucid account of the crime and of his own state of consciousness when ques-

tioned about it in subsequent years, adding, as a symbolic interpretation of the act, that he believed the murder to mean the severing of the tie of spiritual existence—the victory of the force pulling down over the force pulling up, of the reason over the deeper reason. His associations and his very exuberant dream phantasies indicated the predominance of complexes of fear and of masturbation.

The passage from the suicidal impulse to the homicidal impulse, which occurred in this case, is common in dementia præcox, as we have seen it to be in other forms of mental disorder; the frequency with which it is observed in conditions of morbid affectivity affords a striking illustration of the virtual equivalence of these impulses and of their close affinity in nature and origin.

In other instances of murder in an early stage of dementia præcox, the crime may be committed in a phase of marked mental confusion, and the patient may subsequently have no memory, or only a blurred memory, of the act. This was the case in the following observation, where the symptoms bore a close resemblance to those of epileptic furor.

Obs. 23. S. D., aged 22, fitter. Patient, whose father was in a lunatic asylum, lived with his mother and sister, and was employed at a munition factory, where he was regarded as a fairly intelligent and efficient workman. He had shown no signs of being mentally abnormal until some three months prior to the crime, when he began to complain of headache and general weakness, felt unfit for his work, and was moody, taciturn, and irritable. Under medical treatment he seemed to get considerably better, and was able to go back to work. On coming home from the factory the day before the murder, he again complained of being ill, talked about dying and

the devil, greeted the doctor who was called to see him as an "old pal," was alternately boisterous and lachrymose. He had a sleepless night, and next day was very confused, but appeared to be less agitated. In the evening, as he was lying on the sofa, he had what his mother described as "something like a fit," after which he became wildly excited; his mother and sister tried to hold him down on the sofa, and a woman neighbour came in to help them. The patient broke loose, threw himself on this woman, dragged her to the floor and strangled her. It took several men to overpower him and carry him to the station. His state of furor abated somewhat the next day, but he continued to be confused and agitated, with numerous visual and auditory hallucinations, this condition gradually clearing up after some months. On his partial recovery he was unable to give any account of the murder beyond saying that he had a vague memory of struggling with devils as one might in a nightmare. After remaining rational but slightly enfeebled in mind for about a year, patient had a recurrence of active symptoms of disorder, with abundant changing and fantastic delusions and hallucinations of a religious and erotic colour; this attack left the patient in a more enfeebled state, with a tendency to mannerisms and stereotyped speech and gesture.

It will be noted that in this case the phase of confusional violence was ushered in by some sort of convulsive attack which was described by patient's mother as a fit. Seizures of this sort which sometimes are remarkably like epileptic fits are occasionally observed in the course of dementia præcox. When they occur in the initial period of the disease, they are likely to be interpreted as evidence of essential epilepsy, and so it happens at times that, on the strength of a history of such attacks, a motiveless murder is set down to the account of epilepsy until the

further evolution of the case shows the condition to be really one of dementia præcox.

The fact that in the last-quoted observation the confusion and furor, with subsequent amnesia, followed one of these convulsive seizures, obviously suggests the possibility that the blurred recollection of the murder may have been connected with the preceding epileptiform attack, and that other instances of defective memory of criminal acts in dementia præcox may be susceptible of a similar explanation. However that may be, it would certainly appear that such amnesia is relatively infrequent in cases of impulsive crime in this type of insanity. Ordinarily the details of the crime are remembered quite clearly, and when, as often happens, the disease does not go on to a stage of marked enfeeblement of mind, this lucid recollection may persist for many years. For example, a patient who, in an attack of mental disorder of the dementia præcox type in his twenty-ninth year, murdered a professional colleague in whose house he was living, was able to write spontaneously the following account of the affair thirty-five years later :

“ On the Saturday night (or early morning) I suddenly awoke with what I can only describe as strong homicidal tendencies for which I could in no way account. I lay in bed for some time trying to overcome them, till at last giving way to a powerful natural want, I left my bed to attend to it, and found myself quite unable to return to my couch. After a time (under what seemed a strong compulsion) I lighted a candle and put on my dressing-gown, and wandered about my bedroom trying to overcome ‘myself,’ going down on my knees praying to be delivered from such an awful tragedy. I managed to lay down on the outside of my bed, but found myself unable to stay there. On getting on to my feet, I found

myself opposite my dressing-table, when, much against my will, I possessed myself of a razor, which I could not get rid of, try as I would ; my fingers seemed to clutch it as though they were hermetically sealed. Even then I stayed about in my bedroom for some time, taking up my position in front of my chest of drawers. After staying there some time, I tried to get to my bed, in doing which I had to pass my lighted candle, when I felt compelled to take it up (though it was far from my intention), and with it left the room, trying all the time as I walked along the passage to return to my room, but it was not to be. I may add that Mrs. X. [the victim's wife] came out of her room and tried to get the weapon away from me, but I (unaccountably) held it out of her reach. She then retired and locked the door after her. I stood about for some time and tried to get down the stairs, which were just outside her door, but it was of no avail. Then trying the handle, I found it unlocked, with Mrs. X. standing close by. I tried to get her to take the razor away, but she seemed totally unable to do so. I then walked on to the hearthrug and stood there for some time.

"All this time Mr. X. lay in bed, and neither spoke nor made any effort to leave his bed to throw me out of the room. I at length turned to leave the room, but instead of going straight out, I felt compelled to turn to the left, which with another turn brought me to the head of Mr. X.'s bed, where I stood for some time trying to get the mastery of myself, but it was of no use, for at length I felt compelled to make use of the weapon on his throat. I felt sure he would continue lying there, but to my surprise he suddenly jumped up and sat edgeways on his pillow with his feet out of bed, and there I left him."

It was remarked above that an apparently motiveless murder, either with lucid consciousness of an overpowering homicidal impulse or with transitory mental confusion,

may be a very early manifestation of dementia præcox. In a case of this sort, where no indications of disorder of mind have been observed before the crime, and where the murderer's mentality may seem quite normal after its perpetration, the morbid relations of the act must remain in doubt unless the position is made clear by the development of more definite symptoms. But it is, of course, quite possible that, even when no such development occurs, the case may nevertheless be one of dementia præcox, since the evolution of this disease may undergo spontaneous arrest at any stage. In some such instances a qualified presumption as to the origin of the criminal act may be hazarded if the murderer's family history gives evidence of other instances of this type of insanity, or if he himself in his earlier life has shown the peculiarities of temperament usually found in subjects predisposed to dementia præcox.

The following observation is probably to be interpreted in this way :—

Obs. 24. E. W., aged 17, indoor servant. Murdered a boy whom he had never seen prior to the crime. Patient had a family history of insanity on both sides, two paternal great-uncles and a maternal grand-aunt and her two daughters having been under asylum care, with symptoms described as "mania" and "melancholia," followed by dementia. Patient himself was noted in childhood and during his school years as shy and reserved in manner, solitary in habits, and frequently absent-minded. He suffered from bed-wetting till about 9 years of age. At school he showed average intelligence, reaching the 7th Standard, and he was found quite efficient in the household where he was employed for eighteen months before the murder, and where he enjoyed the reputation of being "exceptionally good in his morals."

The circumstances of the murder were these :—The

patient, who was alone in the house, telephoned for a district messenger, and, on the arrival of the boy, hit him on the head with an iron bar, dragged the body by a rope round the neck to an inner room, and left it there, having turned a gas radiator full on and closed the windows and door. He then left the house, took the train to a country village, and there accosted a policeman, saying, "I think I've done a murder," and giving particulars of the place, time, and manner of the crime. He also said, "I've felt bad since I lost my mother last January; I don't know what made me do it." In a pantry adjoining the room where the body was found, letters were discovered in the patient's handwriting, giving an account of the crime and of his own suicide by gas as accomplished facts, and referring also to a previous design to commit suicide, some suspicion of which had been aroused at the time by his tampering with a gun-case. A paper was also found on which the patient had written down a numbered programme of the projected murder and suicide. There were no indications of sexual interference with the victim.

From the time of his arrest onwards the patient showed no evidence of disorder or defect of intelligence, nor, except for his rather unconcerned attitude regarding the crime, did he seem to be emotionally abnormal. He was quick and industrious in his work, took an intelligent interest in reading books and papers, and associated freely with his fellow-patients. There was a rather vague history of his having suffered from "fits" in infancy, but he never presented any indications of epilepsy, though tested with chloride diet after an interrupted course of bromide; and in any case the elaborate planning of the crime and the lucid memory of its execution would exclude the hypothesis of epileptic confusion. These latter features of the murder are, on the other hand,

fully consistent with the view that the morbid condition was one of incipient dementia præcox; and this view is supported by the patient's temperamental peculiarities in earlier life, and by the occurrence amongst his relatives of several instances of insanity of the degenerative type.

Of course, so long as there is no development of more definite symptoms of mental deterioration, this mode of interpreting such cases of adolescent murder must necessarily remain somewhat speculative. And, in some instances, at all events, the facts will, no doubt, admit of fairly plausible explanation on other lines. In particular, it may be suggested that certain instances of adolescent murder, in which there is a very marked sexual colouring, may be due to an irregularity in the evolution of the reproductive instinct, giving rise to a precocious and excessive development of the sadist factor which is probably in some measure a regular constituent of that instinct in its normal form. This point will be further discussed and illustrated by clinical observations in a later chapter in connection with moral imbecility.

When hallucinations and delusions are specially prominent features in dementia præcox, as they are in the paranoid form of the disease, the morbid impulses, and the criminal acts in which they issue, may still show the same apparent irrelevance to the other conscious activities of the subject; or, on the other hand—and this is more frequently the case—they may seem to be in more or less logical relation to the accompanying disorders of thought, the apparent connection being increasingly marked as the delusional ideas are more stable and tend more towards systematization. Thus the impulsive act may be in immediate sequence, and, for the patient's consciousness, in obedience to a hallucinatory command.

Again, it not infrequently happens that patients who are beset by auditory hallucinations, calling them by

opprobrious names or accusing them of vile actions, will react with murderous violence either against some casual bystander to whom they refer the slanderous voice, or against some particular person of their acquaintance whom they have singled out, by a pseudo-reasoning process, as their likeliest enemy. For instance, one patient, whose mother and brother were insane, began to be strange in manner shortly after the death of the former, and complained rather vaguely that his fellow-workmen were calling him names. Some six months later, as he was going home on top of a tram-car, he heard a voice, which he attributed to an entire stranger sitting behind him, say, "You dirty mongrel, you slept with your mother," whereupon he turned round and stabbed the supposed utterer of the insult to the heart. Under detention, when he gradually deteriorated in mind and developed mannerisms and stereotyped gestures, he made frequent attacks on fellow-patients whom he accused of making similar remarks about him.

It is worth noting that the auditory hallucinations in dementia præcox very often take the form of such accusations of incest ; and, further, that homicidal impulses in this disease are specially apt to be directed against the father or the mother of the patient ; dementia præcox is the type of insanity in most of the cases of parricide and matricide in Broadmoor. The point is of interest in connection with the Freudian theory of the Oedipus complex.

The preceding account of criminality in dementia præcox has been concerned solely with homicidal crime ; but this limitation of treatment is not, of course, to be taken as implying that other forms of delinquency may not be related to this type of insanity. As a matter of fact, all sorts of impulsive crimes, and especially arson, wilful damage to property, and sexual offences, are fairly

common as manifestations of morbid impulse in the subjects of this affection. The close resemblance in characteristic features between these less serious offences and the homicidal crimes in dementia præcox is sufficiently illustrated by the following case :—

Obs. 25. P. T., aged 29, clerk. Broke into a church, and destroyed ornaments and furniture. There were no details available regarding the family history and early life of the patient. During the war he was on home service, and was chiefly engaged in clerical work, at which he seems to have been fairly efficient. Demobilized with a small pension on account of chest trouble, he obtained a post in a Government office, and was employed there up to the time of his arrest. Though for some months previously he had appeared rather strange in manner and speech, he was not supposed to be wrong in his mind until the mad exploit which brought him into the hands of the police. He made his way into a church one night, smashed a couple of stained-glass windows, broke the electric lamps and candlesticks, destroyed a figure of Christ, damaged the organ, and made water in the chancel, wiping it up with the altar-cloth, which he tore into pieces. When taken into custody, he was quiet, and at once admitted his guilt, saying that he knew all he had done, but had not been able to stop himself from doing it. During the next few days he was restless, masturbated constantly, and did various impulsive acts, drinking his urine, breaking windows, and bursting into paroxysms of noisy laughter.

On admission to the asylum, he was rather reserved in manner, but on a little pressure, gave a detailed account of the damage he had done in the church ; he said that he could not account for his conduct in any way, except that he had noises in his head, and felt impelled to act as he did. This attitude persisted as long as he was mentally

accessible, his account of the affair varying only in his increasing use of stilted and symbolic language to describe his morbid impulses—"it was an ambition of mine to knock the candlesticks off the altar"—this was not from any anti-ritualistic feeling, "there was no sphere of that in my nature"—"it must have been the monkey in me" (i.e. the red monkey, which provokes him to masturbate, and not the blue monkey, which has other functions). The patient's mental condition deteriorated rapidly; he became dull and inert, with occasional impulsive outbursts—assaulting other inmates, breaking windows, turning somersaults—for which he professed to be unable to give any reason in his more lucid moments.

CHAPTER VIII

CRIME IN SYSTEMATIZED DELUSIONAL INSANITY

It has been already pointed out that the classification of the psychoses, being based solely on symptomatic grounds, is to a great extent arbitrary, and is subject, therefore, to frequent changes according to the fluctuations of psychiatric doctrine. This fact is strikingly apparent in connection with the type of mental disorder which we have to consider in the present chapter.

Formerly, when special importance was attached to the existence of delusion, with relatively little inquiry as to its character and mode of evolution, the limits of the group of systematized delusional insanity, or, as it was alternatively termed, paranoia, were very wide, and practically all chronic lunatics presenting more or less stable delusions were brought into this category. Paranoia, in fact, occupied very much the same position which is now held by dementia præcox, as the fashionable form of psychosis. With the development of an increasingly critical spirit in clinical observation, and especially under the influence of the teachings of Kraepelin, a different and much more restricted conception of this type of insanity has since come into vogue; the majority of the cases of chronic delusion have been attached to other disease forms, particularly to dementia præcox, constituting the paranoid variety of that condition; and ultimately the term paranoia has been confined to a small

group of instances in which the manifestations of disorder consist almost exclusively in an elaborate, coherent delusional system, without accompanying hallucinatory symptoms, and showing no tendency to mental deterioration.

It is not necessary for our present purpose to discuss the validity of this view, or to inquire whether paranoia is separated by any essential difference of nature from the so-called paranoid conditions, or represents merely the fullest development of systematized delusion. It is enough for us to note the fact that, clinically, there appears to be a regular series of cases, ranging from instances, on the one side, of unstable and unorganized delusion, with indications of loss of psychic unity and more or less rapid mental decadence, to instances, at the other extreme, of elaborate systematization of insane ideas with relatively little evidence of other impairment of psychic function; or, to put it in other words, that there is no definite line of demarcation between paranoid dementia præcox, in which the enfeebled mind fails to work out a consistent delusional system, and paranoia, in which a more vigorous mentality permits the development of a connected and quasi-rational scheme of morbid beliefs. Inasmuch as systematization is the element of special importance in the relation of these conditions to criminal conduct, it will be more convenient, in our present inquiry, to ignore the theoretical question of the nature and criteria of paranoia, and to deal with the chronic systematized insanities as a single group, comprising both paranoid and paranoiac cases.

In the clinical group so constituted, the incidence of serious criminality, and the conditions under which it occurs, are found to depend very largely on the degree to which systematization has taken place. In those cases approximating to dementia præcox where the delusions,

though fairly stable, are not combined into any sort of coherent system, and where the disintegration of the psychic unity emancipates impulse from control, there is a liability to prompt and sudden reactions, more or less in harmony with the character of the delusion. Thus the patient who believes that his food is poisoned, or that his virile power is enfeebled by drugs or by electric agencies, but who is incapable of any sort of effort to seek for evidence in confirmation of his suspicions, and does not attempt to explain to himself why he should be singled out for such malignant persecution, will show little discrimination in choosing the object of his vengeance ; he will attack some person whom he suspects of acting upon him for no better reason than the accidental presence of the victim at a moment when his own unpleasant sensations happen to be specially acute. In such instances, the homicidal act may have very much the same character as the purely impulsive act of dementia præcox, and the patient will often lay very slight stress on the delusional justification of his conduct.

In cases of somewhat greater systematization, there may be a little more apparent effort to find grounds of suspicion : the patient will say, for instance, that his mysterious sufferings occur repeatedly when he finds himself in the company of some particular individual, from which he concludes that he must be the persecutor, and he may even test his theory by seeking the society of the supposed enemy, when, of course, he inevitably experiences the expected sensations of discomfort. In further stages of elaboration, there may be efforts to account for the mechanism by which the malign influence is exerted ; fantastic theories of X-rays, of wireless currents, of poisonous vapours, and so forth, are worked out, and trivial incidents, real or imaginary, are noted as evidence of the certain connection of these imaginary

agencies with the individual selected as the persecutor.

In cases evolving after this fashion, homicidal reaction may be delayed for a longer or shorter period, and the patient will probably make complaints and protests, explicit or veiled, before he has recourse to violent measures, and kills, or attempts to kill, his fancied enemy. Sometimes, especially when the persecution is attributed, not to a particular individual, but to some association, such as the Freemasons or the Jesuits, the patient may attack, in a sudden impulsive outburst, an entire stranger, subsequently explaining his act by saying that the victim's suspicious movements showed him to be an agent of the persecuting society, or else that the crime was designed to bring the whole affair to public knowledge. Finally, in the cases of most elaborate systematization, a complete delusional theory is built up, in which the patient not only identifies his persecutors and explains their methods of persecution, but also accounts for the motives of their malignancy—e.g. it is in order to keep him out of the possession of money or estates of which he is the rightful owner, or to prevent him from establishing his claim to exalted rank and titles, or, as an indirect way of compassing such ends, to drive him mad.

The characteristics of criminal conduct in these chronic delusional insanities are illustrated in the following observations, of which the first is concerned with an imperfectly organized system of the paranoid type, dominating the personality and tending to dementia; while the second shows a more organized and limited condition, with relative retention of intellectual activity and adaptation.

Obs. 26. F. R., aged 35, munition-maker. Attempted to murder a fellow-workman. There was nothing special in what little could be ascertained of the patient's family

history or of his earlier life. He reached a good Standard at school, did well during his apprenticeship, and was a steady and efficient artisan. He first showed signs of mental disorder some three years before the crime, when he was employed in a Government munition factory. About this time he noticed that some of his fellow-workmen, and especially the man whom he subsequently shot at, were acting in a peculiar manner towards him. They claimed previous acquaintance with him, which was false, and they showed a suspicious interest in the valuable ideas which he was working out for military inventions. Then one of them said to him that he thought that he (the patient) was going to fall ill, and a couple of weeks after he did, in fact, get rheumatic fever.

Some time later he began to experience an extraordinary degree of sexual excitement, and several women threw themselves in his way. One of these women, under a pretence of skylarking, scratched his neck; shortly afterwards he saw her exchange signals with the man whom he subsequently tried to murder, and he noticed also that she had a "crystallized sore" on her face. Following this episode, the patient had a skin eruption, which he knew, despite medical assurance to the contrary, meant that he had contracted syphilis, and would eventually have general paralysis. Meanwhile he was continuing to develop his schemes of mechanical invention, and had a preliminary interview on the subject at the War Office. Having perfected some of these inventions, he decided to seek a further interview, but was stopped by a "mysterious inhibition" which he attributed to the on-coming paralysis.

Further extraordinary experiences, which the patient recorded in minute detail in his diary, followed in the succeeding months, and his morbid ideas crystallized into a comparatively stable delusional system, according

to which a number of the men at the factory, amongst whom his eventual victim was the leader, had given him various diseases and debilitated him in other ways, with a view to making him "a hoste, that is, a man who can find out anything"; by this means they stole the ideas from his mind "by a subconscious test," in order to communicate them to the Germans. On several occasions the patient threatened these "Emotion Merchants" with legal action or personal violence, if they continued their nefarious practices, and he made complaints about their conduct to Scotland Yard in interviews and by letter. Owing, however, to "inhibition," he could not put his case properly. Eventually, as things continued to go from bad to worse, he became desperate, and resolved to take the law into his own hands. He accordingly lay in wait for the ringleader of the miscreants, as he was coming home from work, and, after reminding him of the warnings he had already had, fired on him twice. In the asylum the patient's delusional system has continued to develop, taking in fresh material from the institutional conditions, and occupying his thoughts and conversation and dominating his conduct to the almost entire exclusion of other interests.

Obs. 27. J. D., aged 56, retired Army officer. Attempted to murder a neighbour by shooting. There was no evidence of nervous taint in the patient's family, and he showed no signs of mental abnormality in youth or during his very creditable career in the Army. At the age of 44, when on service abroad, he had an attack of heat apoplexy, in consequence of which he was invalided. Some six or seven years after his retirement, while living at a naval port, he began to notice that his bed was mysteriously moved from the wall at night. He paid no attention to this at first, but as he found that the same thing happened regularly at 2 a.m., and could not

be accounted for otherwise, he came to the conclusion that it was done by some electrical agency. He also observed that his rheumatic pains were taking on a new and unnatural character. Presently his suspicions were confirmed by overhearing remarks from his neighbours which were obviously directed at him. And soon after, he had definite proof through hearing the voices of women in the next house, saying "Pull him," when his pains would get worse. As he had knowledge of certain immoral practices on the part of some naval officers in the town, he suspected that they were responsible for the annoyances, and he concluded that they were making use of a machine well known in the Navy—"a portable reservoir which can be filled with electricity, and is provided with a tap, on opening which the electricity is projected to a distance varying with the degree of opening."

On account of his rheumatism, he used to get about in a self-propelling chair, and he noticed that he was frequently followed by persons carrying something like a camera, which had the effect of locking the wheels of the chair; at such times he would hear a voice saying, "Put it on the brake." When this persecution had continued for about two years, he went away in order to escape from it, but in the town to which he moved the troubles recurred after a few days of peace, and he now remembered that a naval petty officer had travelled in the same train, and had looked at him intently. It was clear, therefore, that his enemies were engaging agents to carry on the same persecution in his new residence. He complained to the police, with the result that he was sent to the local asylum, where he was detained for four months.

A short time after his discharge the annoyance began again, and he now felt that the position was becoming

intolerable, and that he must take more active measures for self-protection ; he accordingly took to carrying a loaded revolver and keeping an open razor by his bedside. On the morning of the murder, having passed a sleepless night, owing to his delusional torments, he told his wife that he was resolved to do justice on his persecutors ; she endeavoured to dissuade him, and he then proposed that he should put an end to the trouble by shooting her and committing suicide. At that moment he saw his next-door neighbour, whom he specially suspected, cross the lawn in front of his house, whereupon he rushed into the garden, shot the man, and walked quietly back to the house, where he awaited the arrival of the police.

In the asylum, the patient is quiet, orderly, and courteous ; he shows acute intelligence in the management of his affairs, and in his conversations on general subjects. He regrets his violent action, but considers that the terrible provocation which drove him to it makes his loss of self-control excusable. He rarely refers to his persecutory ideas, but occasionally produces a minute record of abnormal experiences and of trivial actions on the part of attendants and patients which he interprets in the sense of his delusional system.

In the more elaborately systematized cases of this type of insanity, serious disorder of conduct is usually a comparatively late occurrence, and, as instanced by the two observations just quoted, it is generally preceded by such warning indications as show quite clearly that the patient is approaching the period of dangerous reaction. Thus, before he takes the law into his own hands, the paranoiac will probably try legitimate methods for obtaining protection or for ventilating his grievances ; he will appeal to the police or to other constituted authorities, or will address remonstrances or threats to the person whom he holds responsible for his sufferings. And

frequently, when he does have recourse to acts, it may, at all events in the first instance, be by way of demonstration and protest rather than with definitely homicidal intent : he may fire on some prominent public man, but only with blank cartridges ; or he may discharge a pistol in the air, or make a more or less technical assault ; sometimes he merely breaks a window.

Owing to this relative retention of self-control which marks the earlier stages of persecutory paranoia, the contribution which this form of insanity makes to serious homicidal crime is much less than might be expected from the character of the delusional ideas. The evil reputation which attaches to patients suffering from this type of disorder is based more on their attitude while under restraint than on their actual criminal achievement before they find their way to the asylum. This applies, of course, only to the instances of comparatively slow systematization, approaching the type of paranoia in the narrower sense of the term. In the cases of less complete and coherent delusional evolution, where the mental disintegration involves a marked and early emancipation of impulse, there is, on the contrary, from the onset of the illness, a pronounced tendency to violent reaction, and patients of this paranoid class are peculiarly apt to commit murder, especially when, as is very frequently the case, their delusional fantasies refer to sexual matters, and their morbid impulses are accordingly reinforced by energy drawn from the reservoirs of the sexual instinct.

Though the more purely paranoiac cases thus play only a comparatively small part in homicidal crime, they have bulked very largely in theoretical discussions concerning the effect of insanity on conduct, and in this way they have exerted a somewhat unfortunate influence on legal conceptions of morbid psychology. The paranoiac

is the type of lunatic who seems to give the most plausible support to Locke's dictum that the madman reasons correctly from false premises : the pseudo-logical connection which appears to exist between the morbid beliefs and the morbid acts of the chronic delusional patient is readily interpreted as confirming this fallacious theory. As a result, the legal view of insanity, which is largely based on this doctrine, attributes a grossly exaggerated importance to the fact and content of delusion, and ignores almost entirely the primary and dominant influence of morbid impulse. We shall see the consequences of this erroneous attitude when we come to discuss the question of criminal responsibility in relation to mental disease.

CHAPTER IX

EPILEPSY AND CRIME

In estimating the importance of epilepsy in relation to crime, it is necessary to take due account of the special circumstances which tend to give an exaggerated prominence to this disease in medico-legal practice. It is a disease which is familiar to the general public by repute, and very frequently by actual observation ; its occasional association with acts of motiveless violence is a matter of common knowledge ; the possibility of its manifestation in attacks which are infrequent in their occurrence, and ill-defined and anomalous in their character, is notorious. Add to this the dramatic features of the epileptic fit, which in the past have invested the malady with a mystical interest, as a sign of divine influence or demonic possession, and it is easy to understand how useful may be a suggestion of epileptic automatism in a case of murder where the defence of insanity would be otherwise somewhat feeble.

It is possibly on account of its value in this respect rather than from its real significance as a cause of criminal conduct that epilepsy has bulked so largely in medico-legal controversy. That, at all events, would seem to be a probable inference from the fact that this disease, so far from being exceptionally common in insane homicides, shows practically the same incidence on the criminal lunatic population as on the inmates of ordinary asylums. Thus the proportion of epileptics amongst the patients

admitted to Broadmoor since the opening of that institution has averaged about 7 per cent. of the male patients and 5 per cent. amongst the females, while the corresponding figures for the ordinary asylum population in England and Wales are 7·1 per cent. and 5·6 per cent. respectively.

It would appear, therefore, that, at all events as regards distinct and unequivocal cases of epilepsy, this neurosis is not associated with an abnormally high proclivity to seriously criminal conduct ; and it is probable that it owes some of its unfounded reputation in this kind to the tendency to ascribe to epilepsy a large number of anomalous mental states which may be due to quite other causes. In this way we may perhaps explain the very high estimates of epileptic crime which have been given by some observers, especially in Italy, and which seem to include under this rubric the impulsive acts committed in such conditions as alcoholic automatism and the confusional phases of melancholia and the exhaustion psychoses. There may, no doubt, be a considerable similarity of character, and perhaps also of mechanism, between the morbid impulses arising in some of these states and the morbid impulses in epilepsy, and an epileptic element may frequently co-exist with other types of mental disorder ; but this is hardly a sufficient ground for extending indefinitely the conception of the neurosis, and for adopting the principle, *omne ignotum pro epileptico*. It will be more convenient here to take a somewhat narrower view, at all events in the first instance, and to start from the consideration of cases of unquestionable epilepsy, cases, that is to say, associated with convulsive seizures or characteristic episodic disorders of consciousness.

The mental aberrations connected with epilepsy may arise in definite relation to the fits, or may be manifest

also in the inter-paroxysmal periods, either in the form of the morbid epileptic temper, or in more or less systematized delusional states, or as a progressive deterioration of mind. In connection with criminal acts, we have chiefly to consider the disorders of consciousness immediately related to the epileptic attacks, but it is important to note that in a large proportion, perhaps, indeed, in a majority, of the cases of grave epileptic criminality, the offenders show well-marked evidence of mental abnormality apart from their fits ; the epileptic homicide is very commonly not merely epileptic, but is also insane or weak-minded in the intervals between his seizures.

The periodic mental disorders of epilepsy are divisible, according to their relation to the characteristic paroxysms, into those preceding the fit, or pre-epileptic disorders, usually in the direction of morbid irritability, those following the fit—post-epileptic dream-states or maniacal outbursts of longer or shorter duration—and those occurring in lieu of a fit, or possibly after a very slight and unobserved attack of *petit mal*. Criminal conduct, and particularly acts of homicidal violence—for homicide is *par excellence* the crime of the epileptic—may occur in connection with any of these disordered conditions. Its most frequent and characteristic form is the homicide committed in the phase of obscured consciousness which may follow or replace a fit or an attack of epileptic vertigo.

In some instances of this sort the automatic act, though homicidal in effect, is not the outcome of a homicidal impulse : it is merely a continuation, in an inappropriate or muddled form, of the action in which the subject happened to be engaged at the moment of the epileptic seizure. The classic illustration of this kind of accident is the case of the woman who, having a slight vertiginous attack while in the act of cutting bread and

butter, went on with the cutting movements during the automatic phase, and cut her child's arm off. The two following observations are parallel cases, though in the second observation a definite homicidal impulse may have existed.

Obs. 28. H. W., aged 29, married woman. Killed her 2-year-old child by putting it on the fire. The patient had "teething fits" in childhood, and about the age of 17 began to suffer from major epileptic seizures, occurring at irregular intervals. She was usually dazed for some time after these attacks, and occasionally did erratic acts of which she had afterwards no recollection—e.g., on one occasion she picked up the cat and tried to put it on the fire.

The tragedy occurred while the patient was alone in the house with the child: she was found in a confused condition, nursing the infant, who was severely burned on the buttocks and legs, having apparently been placed in a sitting posture on the fire, with the clothes lifted up. The patient, on coming back to her normal state, said that the last thing she could remember was starting to get her husband's tea, and filling the kettle with a view to putting it on the fire: from that point her memory was a blank until she saw her mother holding the child in her arms, and learned what had happened. The kettle was found on top of the oven. Apparently in the automatic phase the patient resumed the operation interrupted by the fit, but substituted the child for the kettle, probably lifting up the child's clothes as in the habitual act of seating it on the chamber utensil. The epileptic fits, which continued to recur while the patient was under asylum care, were frequently followed by phases of confusion with automatic acts and subsequent amnesia.

Obs. 29. H. J., aged 28, married woman. Strangled her 9-months-old child with a piece of chiffon. Patient

had been subject to "bilious attacks" from the time of puberty; at the age of 19, when three months pregnant, she was attacked and injured by a bull, and aborted a few days later; soon after this mishap she had her first epileptic fit. From that time onwards she had frequent epileptic attacks, usually at her menstrual periods. The crime occurred when she was menstruating for the first time since her last confinement. On the morning of the day her husband went to work at 4.30 a.m., and she remembered that she then gave the baby the breast. She also remembered giving their breakfast to her other two children and sending them to school; this would be about 8.30 a.m. Her husband then came in, and she went upstairs to fetch the baby, as she usually did at this time; she found the child in bed, strangled with a piece of chiffon which she was in the habit of using herself as a neck-tie. Though the act may have resulted from a definite homicidal impulse, the selection of this bit of finery for putting around the baby's neck is possibly suggestive of a mere muddling of a customary action.

In the class of cases illustrated by the first, and possibly also by the second of the above observations, there is a resumption, in the post-epileptic state, of an ordinary and habitual act which was in process at the time of the attack. In other instances, conduct in the automatic phase appears to be determined by the antecedent emotional tone, and to represent a development in action of the impulses related to that tone. Thus Magnan¹ has recorded the observation of an epileptic who was in a state of depression owing to loss of employment, and who, as he was sitting on a bench by the riverside, brooding over his misfortune, had a fit, and in the confusional state following it, jumped into the Seine. On recovery, he had no recollection of what he had done, and ridiculed the

¹ Magnan, *Leçons cliniques sur l'épilepsie*, Paris, 1882.

notion that he had tried to commit suicide, because, though he admitted thinking of killing himself, he was an expert swimmer and would never have selected drowning as a means of self-destruction. The following case of attempted suicide shows a similar mode of influence :—

Obs. 30. R. R., male, aged 20. From the age of 17 suffered from epileptic fits with epigastric aura, the attacks being sometimes of the classic type, and sometimes limited to manifestations of *petit mal*. A craniectomy had been performed for the relief of the condition, but without beneficial effect. The fits were often followed by confusional phases, during which the patient had assaulted his relatives and performed other undesirable actions, but had never shown any suicidal tendency. On account of his epilepsy he was dismissed from a good clerical post which he held, and had in consequence been very much worried and depressed, but had not entertained any idea of suicide. In the confusional state following the first fit he had after his dismissal, he went from his home to a neighbouring chemist's shop, and purchased some carbolic acid, the shopman observing nothing peculiar in his demeanour. He was seen in the act of putting the bottle to his lips, and was stopped by a passer-by, and taken to the police station. Shortly afterwards, he asked where he was and what was the matter, and said that he remembered nothing from the time—about half an hour previously—when he had felt the epigastric sensation which preceded a fit.

The impulses associated with the pre-epileptic emotional state may, of course, be homicidal instead of suicidal in character, and this appears to be the explanation of some epileptic murders, as in the following observation :—

Obs. 31. M. S., aged 29, fish salesman. Patient had suffered since puberty from typical fits of major epilepsy,

the attacks being frequently followed by some degree of mental confusion with a tendency to automatic action. On the morning of the murder, he had a dispute at the fish market with the man from whom he was in the habit of buying his stock. He was very much irritated by the episode, and talked bitterly of his grievance before he went home. Some hours later he arrived at the house of a relative, and forced his way in, acting in a violent and threatening manner, and being obviously in a state of great mental confusion. Seeing that his hands and clothes were stained with blood, his friends hurried to his home, and there found the patient's wife dead, with her throat cut. On coming to himself, the patient had no recollection of the crime, and could not believe that he had killed his wife, to whom he was known to be devotedly attached. He remembered that he felt very bad on getting home, that he had gone to bed, and that his wife had given him a cup of tea. He had also a vague memory of making his way to his relative's house, which was near the fish market, and of his preoccupation at that time with the idea of the injury he had suffered at the hands of the swindling salesman.

In this last observation, the angry emotion existing before the fit was provoked by a real experience, and was in some sense normal. But not infrequently in epilepsy a similar emotion arises as an element in a temporary state of mental disorder preceding and ushering in the epileptic attack, and the homicidal act in the post-epileptic phase appears then to be determined by the character and direction of the morbid feelings and ideas of this pre-epileptic condition. The following case illustrates this point:—

Obs. 32. W.E., aged 37, blacksmith. Murdered a man, and wounded several persons in an attack of post-epileptic furor. Patient had suffered from epileptic fits

from childhood. For some years the attacks were occasionally preceded by phases of morbid emotion, ill-defined anxiety and apprehension of impending evil, with vague persecutory ideas. On the evening before the murder he accompanied his mother to the house of a friend. While there he complained of feeling ill, said he was going to die, and asked those present to pray for him. His mother and the friend took him home ; he had a slight epileptic attack, after which he laid down and slept. About half an hour later he awoke, and, addressing his mother and the neighbour, who had remained in the room with him, accused the latter of having tried to poison him. As he became increasingly threatening, his mother went to summon assistance, whereupon he followed her, dragged her back, drew a knife and threatened to kill her. Some men armed with sticks came in, rescued his mother, and got the knife away from him. The patient, now in a state of furor, broke loose, got possession of one of the sticks, and made an onslaught on the rescuing party, felling one of them to the ground and battering in his skull by repeated blows. He was eventually overpowered and taken to the police station. When charged with the murder, he said that " they had worked him up, so that he could stand it no longer, watching and peeping about the house," adding that he " had given G—— [the man he killed] one." After a time he calmed down, and then professed to have only a confused recollection of the affair, but remained sullen and morose, and appeared still to harbour some morbid suspicions regarding his family and neighbours. After serving a long term of years in prison, he became mentally enfeebled and his epileptic attacks were associated with increasingly severe and violent phases of maniacal excitement.

The fact that transitory moods of suspicion and malignancy are apt very often to develop in the relatively clear

consciousness of the pre-epileptic period, shows that morbid feelings and impulses may be immediate manifestations of the neurosis ; and it is not surprising, accordingly, to find that in many instances of murder in the post-epileptic dream-state the crime appears to be due to a pure homicidal impulse. This type of epileptic homicide is illustrated in the following observation :—

Obs. 33. M. B., aged 66, married woman. Murdered a little boy, a stranger to her, by cutting his throat. The patient's family history was rather fragmentary, but it was alleged that one of her sisters had suffered from "fits," and that her mother had committed suicide. The patient herself had seven illegitimate children by her uncle, and one of these was an epileptic idiot. Up to some years before the crime the patient had had good health, but had been of intemperate habits ; on at least one occasion she had attempted suicide, probably under the influence of alcohol. When about 60 years of age, she began to suffer from sudden attacks of dizziness, in which, according to her own account, she did not entirely lose consciousness, but was unable to see or speak ; in some of these "dizzy turns" she fell and hurt herself. These attacks were followed by intense headache. They occurred more often when patient had been drinking, but also occasionally when she had been entirely abstinent. The attacks became more frequent and severe in the next few years, and the patient now had sometimes phases of dreamy consciousness in which she would wander from her home, and would be unable to recollect where she had been or what she had done.

In one such phase she went out of her house, met a number of children coming out of school, and threw one of them into the river. For this act, of which she professed to have no memory, she was sent to prison for three months. In gaol she was observed to have frequent

vertiginous attacks. On her release she returned to her home, and some two months later murdered the boy. About 1 p.m. on the day of the crime she went into the next-door neighbour's house, told her that she was feeling ill, that she had been to see the doctor, who had given her a plaster, and that she was going to lie down. The neighbour did not notice anything strange about the patient's demeanour, and the story about the visit to the doctor—which was in fact quite imaginary—was related clearly and naturally. The patient then went back to her own house, and a few minutes before 2 p.m., walked down the road, met the children going to school, caught hold of one of them, and, producing a knife from under her cloak, cut the child's throat, after which she returned quietly to her own cottage. When the police went there some twenty minutes later, she appeared rational and collected, and, when questioned about the affair, professed entire ignorance of what had happened, saying, "I have not seen the boy, I don't know him." The doctor who saw her shortly after at the station, and the other witnesses, were all impressed by the apparent sincerity of the woman's denials. There was no evidence that she had had any liquor that day, and she certainly showed no signs of having taken alcohol recently. The patient's story, to which she adhered consistently, was that she had no memory of the crime, of the preceding visit to the neighbour, or of her arrest by the police; she remembered quite clearly getting the dinner ready between noon and 1 p.m., but from that point, she asserted, her memory was a blank until she found herself at the police station, and, in conversation with the sergeant's wife, heard what had happened. She denied ever having conscious homicidal impulses, nor did her dream memories or the results of association tests suggest any such tendencies.

To ascertain whether the phase of automatism was specially related to alcohol, the patient was given large doses of brandy, but without inducing any vertiginous attack, and without any perceptible modification of the pupillary reactions or the tendon reflexes. This negative result, and the fact that the attacks continued during the enforced abstinence in prison and subsequently in the asylum, pointed to the conclusion that the case was one of minor epilepsy and not of pathological drunkenness.

A primary homicidal impulse may also arise in epilepsy in states of clear consciousness, and apparently unrelated to any sort of fit. This would seem to have been the case in the following observation :—

Obs. 34. M. H., aged 42, labourer. Murdered a boy of 9 years of age by cutting his throat. Patient had suffered from epilepsy since adolescence, and had been observed to be frequently dazed and irritable for some time after his fits. Three days before the crime he had taken his discharge from a Workhouse Infirmary, his reason for doing so, as appeared from his subsequent statements, being a delusional belief that officials of the institution had tried to poison him. He met the boy, who was an utter stranger to him, cut his throat, and went direct to the police station, and said what he had done. The only explanation he could give was that he had a sudden impulse to kill the child. On further questioning, he said that he had had a fit that morning, but that this was some hours before the murder, and that he had got over it. During his asylum detention, he had typical epileptic fits at rather infrequent intervals, and was occasionally suspicious, excitable and violent, but for the most part was well-conducted, sociable, and rational, though slightly enfeebled in mind.

The development of a conscious homicidal impulse without any associated idea of motive, may be illustrated also by the accounts which epileptics will sometimes give of the manner in which they are occasionally beset by morbid feelings and morbid impulses of aggression, alien to their natural disposition, and seeming to them to result from some agency independent of their own personality. The following complaint, made by an epileptic murderer whose ordinary mood is friendly and optimistic, is an interesting example of introspection in this state of pathological emotion, and is also instructive as suggesting the close similarity of mechanism in the motor and the mental convulsions of the disease. "I wish to complain that images are formed in my mind of my relatives as well as of the pictures which I look at in some of the papers. Moreover irritating suggestions and bad thoughts are imparted through my head and eyes off and on during the night and day, which has been going on for more than twelve months. I am suddenly made to feel hateful towards inmates who do me no harm, and strong impulses suddenly come upon me to induce me to grumble at my food, but I will not do so to please such a prompter while I have any will power left. Further I am prompted to strike inmates who do me no harm, but I get up and leave their presence until the inclinations pass off. Furthermore vibrations run up my legs and nervous system. I also have surging elementary sounds in my ears and my tongue, lips and muscles of my mouth are also tampered with so much that at times I find a difficulty in speaking owing to the false shapes made upon the speech organ. And finally I complain of being knocked insensible by a strong force which is set in motion on the instant the force runs through head, eyes, ears, legs, therefore I hope you will please order it all off or out of bed."

From the medico-legal point of view there is comparatively little difficulty in a case of murder when the offender is a known epileptic, when his condition at or about the time of the act is obviously strange and disordered, and when the crime itself is motiveless and is marked by the blind and extravagant violence which commonly characterizes epileptic homicide. When all these conditions are satisfied, they warrant acceptance of the murderer's plea that he has no memory of the crime. It is otherwise when the evidence of epilepsy, apart from the culprit's allegation of amnesia, rests mainly on vague statements from interested relatives to the effect that the accused has suffered from occasional "faints" or "turns," or when the fits have been mainly nocturnal, and so have escaped notice, or when, as may conceivably be the case, the crime has been committed in sequence to a first epileptic attack. In doubtful cases of this sort, it may sometimes prove useful to put the supposed epileptic on a moderate course of bromide for some weeks, then to stop the drug abruptly and to give him a diet specially rich in chlorides. If an epileptic tendency is really present, this treatment will frequently, though not, it would seem, invariably, induce a fit.

Of course, proof that an offender suffers from epilepsy does not by any means justify the inference that his alleged amnesia of the crime is genuine. Epileptics may commit murder with full consciousness of what they are doing, with some amount of method, and from more or less rational motives of vindictiveness, and may then endeavour to escape punishment on a false plea of automatism. This is uncommon when, as is frequently the case, epilepsy is associated with moral imbecility, as in the following observation :—

Obs. 35. H. J., aged 26, labourer. The patient suffered since childhood from epileptic fits, in which he

repeatedly bit his tongue and hurt himself in falling—on one occasion he fell into the fire. He is of defective intelligence, grading at about 9 years on the Binet-Simon scale. He served several prison sentences for larceny and assault, and while in the Army—from which he was discharged on account of epilepsy—he repeatedly incurred disciplinary punishment for absence without leave, possibly, though not probably, owing to epileptic fugues. The circumstances of his crime, according to the evidence given at his trial, were these :—

About dusk one evening as he was coming out of a public-house with a female companion, three girls passed by, one of whom made some remark which the patient's friend resented. She accordingly went up to the girls in an aggressive manner, whereupon two of them took to their heels, and she ran after them. The patient approached the third girl, and was seen by a policeman, standing some little way off, to strike her in the neck and to run away. Her throat was fatally cut. The patient, now rejoined by his girl friend, ran down a by-street, turning his cap inside out to disguise himself. He met a soldier in his flight, and asked him the way, saying that he had done a murder and was trying to escape. When captured, after a short chase, he admitted his guilt, and produced from his pocket the razor which he had used. Next morning he professed an entire absence of memory from the time he left the public-house till he "came to himself" in the police cell. For some time after his trial, at which he successfully set up the plea of insanity, he persisted in this story of complete amnesia ; but eventually he became more communicative, and gave a detailed account of the crime, and of his efforts to elude capture, his statements on this latter point showing a clear recollection of the whole affair.

The explanation which he gave of the murder was that

he had a grudge against his victim, whom he suspected of having picked his pocket when he was drinking with her in a public-house on a previous occasion. There was some reason to think that he had other and less trivial motives which he did not wish to divulge ; but his defect of intelligence and his moral insensibility are so marked that even such an absurdly inadequate grievance may have sufficed to explain the act. While under detention he has had typical attacks of major epilepsy at long intervals. These attacks have not up to the present been associated with any tendency to post-epileptic automatism, but the patient has given ample evidence of his moral imbecility apart from his fits.

In this case the behaviour of the murderer after the act, the lucidity of consciousness shown by his flight, by his alteration of dress, and by his inquiry as to the best road for escape, and his admission of guilt when arrested, were quite sufficient to disprove his subsequent story that he had no memory of the crime and of the incidents following it. It is true that conduct in the dream phase of epilepsy may be of an extremely complex kind, and may present a succession of well co-ordinated acts of apparently purposive character, which nevertheless cannot afterwards be recalled in memory ; the murder of the little boy described in Obs. 33 is a striking example of the possibilities of such elaborate conduct with subsequent amnesia in this state of disordered consciousness. But this sequence of acts, however complex, follows the line of a single directing impulse ; when the impulse has attained its end, the agent does not, in the continuing dream-state, adjust his conduct to the consequences arising from the preceding act, he does not, for example, like the malingerer in the last observation, try to save himself by flight and disguise. Such modification of conduct in adaptation to new conditions and new ends

may, no doubt, occur, if not in epilepsy, at all events in other states of disordered consciousness; but in these cases the amnesia is probably never absolute; there is always a more or less blurred and fragmentary memory of some of the incidents in the dreamy state. This point will be further discussed in the next chapter when dealing with crime in relation to other causes of temporary clouding of consciousness.

In regard to this aspect of epileptic crime it should, however, be borne in mind that a false allegation of amnesia is not, in itself, a conclusive proof that the criminal act may not have been done in a phase of automatism; a weak-minded epileptic who, on emerging from the dream-state, sees that he has committed murder, may attempt, in a feeble way, to conceal his guilt by flight or by hiding his victim's body, and, when detected, may profess to have no memory either of these attempts or of the crime itself, his assertion being true as regards the murder, but false as regards his subsequent conduct. Theoretically, at all events, such a position is quite conceivable, especially as it is well known that genuine psychopathological conditions are often associated with an element of malingering; and there are on record some rare instances of epileptic crime where a combination of real and simulated amnesia appears to be the most plausible explanation of the facts.

So far we have been concerned solely with epileptic murder; and it is, in fact, mainly in relation to homicidal crime that epilepsy is of practical importance. But the neurosis is also occasionally associated with other forms of delinquency. Thefts, in particular, are sometimes committed in phases of automatism; and the increase of sexual function which occurs in some patients before or after a seizure may lead to rape or indecent assault. Another crime which may be connected with epilepsy is

arson. In their essential characteristics and in their relation to the episodic symptoms of the disease, these various offences present much the same features as have been described in dealing with epileptic homicide, so that they do not call for any separate and detailed examination.

Before passing from the consideration of epilepsy proper, it is necessary to refer to the occurrence of epileptic symptoms in other morbid conditions which may be associated with criminality. It was pointed out in Chapter VII that convulsive seizures, which may be clinically indistinguishable from ordinary epileptic fits, are occasionally observed in the course, or perhaps more frequently, in the prodromal stage of dementia præcox; and epileptiform attacks may also, of course, be met with in organic dementias, and with notable frequency in general paralysis. When criminal acts are committed by persons in early and undeveloped stages of any of these conditions, a history of such fits or of other pseudo-epileptic symptoms is very apt to suggest epilepsy as a hopeful line of defence, and so it naturally comes about that many instances of pathological crime are erroneously attributed to this disease: it is probable that the tendency to over-estimate the part of epilepsy in crime is in some measure due to this misinterpretation.

There is, in particular, one group of cases presenting such epileptic features, which is sufficiently distinctive, and of sufficient importance in connection with crime, to call for special reference. It is the group which has been described by German alienists under the denomination of "Affect" epilepsy. In these cases, to which attention was first drawn by Bratz,¹ the patients, who are of psychopathic temperament and usually belong to markedly psychopathic stocks, are subject to occasional fits of typically epileptic character, generally occurring

¹ Bratz, in *Monatsch. f. Psych. u. Neurol.*, vol. 29, 1911.

under the influence of emotional excitement. They do not appear, however, to be true epileptics, for their attacks never lead to mental degeneration, nor are they affected by bromide treatment. From the criminological point of view, the interest of this condition is that it is very frequently associated with evidences of moral debility and perversion, in the form, more particularly, of pathological lying and swindling. It is characteristic of "Affect" epilepsy that the convulsive seizures rarely, if ever, occur while the patients are under institution care: and this circumstance is perhaps somewhat suggestive of an element of simulation in the attacks. This condition will be further referred to, and will be illustrated by clinical cases in the discussion of moral imbecility in Chapter XII.

The fact that the mental disorder due to epilepsy may be limited to brief confusional states in immediate connection with the fits, makes epileptic automatism a peculiarly useful ground of defence in cases of murder, when there is no doubt as to the sanity of the murderer prior to and since the crime. And it is a plea which it may be difficult to refute effectively, if it is supported by any plausible history of fits or of anomalous nervous attacks at any period of the accused person's life. As in genuine epilepsy fits may be very infrequent, their non-occurrence in the interval between the crime and the trial has only a qualified value as negative evidence; and if there is a bona-fide history of fits in the past, they may never have been witnessed by a competent observer. Apart, therefore, from such evidence as may be obtained from the experimental device referred to on page 143, the diagnosis in such cases has to be based mainly on the accounts given by the subject himself, and by others, of the alleged fits, and on proof of the presence or absence of an hereditary or acquired cerebral condition which would involve a

predisposition to epilepsy. The hypothesis of epilepsy may also be supported by a history of occasional bed-wetting, and by the existence of scars or other evidences of injuries sustained by falling in fits. It is also sometimes asserted that scars on the tongue, resulting from the biting of that organ in convulsive attacks, may be frequently found in epileptics, and should be looked for in doubtful cases. As a matter of fact, however, such scars are rarely observed; even severe lacerations of the tongue usually heal without leaving any perceptible mark.

The inferences to be drawn from the circumstances of the criminal act, and from the character of the alleged amnesia, will be examined in the next chapter when treating of other transitory states of mental disorder.

CHAPTER X

CRIME IN TRANSITORY CONDITIONS OF MENTAL DISORDER

The facts of morbid criminality which are the subject of consideration in the present chapter form a rather heterogeneous group which in their psychopathological character and in their forensic aspects bear a very close resemblance to the phenomena of epileptic crime. They are familiar to medico-legal practice in the very frequent instances in which crime, usually homicidal crime, is committed in what are alleged to be conditions of blurred or obscured consciousness, by individuals who are not definitely epileptic, that is to say, in whom there is no evidence, prior to the criminal act or in their subsequent history, that they have suffered from convulsive seizures or from characteristic absences.

In some of these cases the pathological condition underlying the impulsive acts may be referred with more or less probability to one or other of the types of disease which have been discussed in previous chapters. Thus, in some instances, though the criminals themselves have never shown any unequivocal signs of epilepsy, the frequency of that neurosis in their near relatives, and the character and circumstances of the criminal act, may warrant the conclusion that the crime was essentially a manifestation of epilepsy. In other instances the eventual development of symptoms of dementia præcox may provide a retrospective explanation of the source and nature of the

transitory state of mental confusion and of the morbid impulse associated with it. And other instances again may be confidently set down to the account of pathological drunkenness.

But, when the cases which can be reasonably allotted to one or other of these several diseased conditions are excluded, there remains a residual group of seemingly impulsive and motiveless crimes, whose pathological nature is indicated, not only by their irrational character, but also by corroborative evidence that they were committed in conditions of temporary disorder of consciousness. As we shall see, these cases of morbid crime cannot be sharply distinguished from the instances referred to above, in which acts of similar type may be attributed to early or imperfectly developed states of some definite disease form; they are commonly related to similar pathological conditions in the individual or in the stock, the difference being mainly in the more attenuated degree of these conditions in the latter group. It is, nevertheless, convenient to give them separate consideration, if only on account of their great practical importance from a forensic point of view.

In the large majority of these cases, the chief, and it may be the only direct evidence of disordered consciousness, apart from the craziness of the crime, is the assertion by the criminals that they have no memory, or only a clouded and partial memory of the acts laid to their charge; and the main question at issue is then whether this alleged amnesia is real or simulated. It is a question which often presents extreme difficulty, and in attempting to answer it, we have to be on our guard, not only against an excessive credulity, but also against an excessive scepticism. The allegation of amnesia is, of course, a very convenient excuse for crime, and it is undoubtedly put forward in many cases with no shadow of justification.

It is obviously very easy for a person who has committed murder to say that he remembers nothing about it, and it is by no means rare for criminals who have escaped the death penalty on this plea, to recover their memory with remarkable celerity as soon as the assumption of amnesia has served its purpose. Though, even in such cases, it should be borne in mind that memory may be simulated as well as amnesia, and that, when his neck is no longer in peril, a murderer may have a quite adequate motive for denying a morbid propensity which might cause him to be regarded as potentially dangerous for the rest of his life. But the fact that this plea may be, and frequently is, abused, is merely a warning against its uncritical acceptance; it is no argument for its indiscriminate rejection.

When amnesia of a criminal act is alleged, there are three main possibilities to be considered:—

(i) The act may have been committed in such a state of disordered consciousness that no trace was left in the memory.

(ii) Consciousness may have been more or less clear at the time of the act, but the painful memory of its details and circumstances may be repressed.

(iii) Memory of the act may be clear, but amnesia may be alleged with intent to deceive.

A special source of difficulty in differentiating between these several possibilities is that very similar constitutional conditions may frequently be associated with all of them. The neuropathic predisposition which leads to apparently motiveless impulsive crimes may be due, for instance, to an epileptic tendency, as evidenced by the occurrence of epilepsy in the family history; in such a case the hypothesis of a true epileptic amnesia is plausible. But the same predisposition is also consistent with the repression of the memory of the act; and it is also fully

consistent with deliberate simulation, for the neuropath of epileptic stock is very often a moral defective and an incorrigible liar. As was pointed out in Chapter IX, undoubted epileptics who have committed murder in the interparoxysmal period with quite lucid consciousness, will sometimes allege that they were in a state of post-epileptic confusion at the time, and that they have no memory of what they did. Another point to be noted is that incidents occurring at the time of the criminal act, such as injuries sustained in attempting suicide or in efforts to escape, will sometimes produce a retrograde amnesia covering the period of the crime which has been committed in a state of lucid consciousness. A further element of confusion is that in cases where the memory of the crime is repressed, a false memory may be subsequently evolved, which may easily give rise to an erroneous suspicion of malingering.

To arrive at an opinion whether the alleged amnesia of a criminal act, in such cases as we have here in view, is genuine or assumed, we have to rely mainly on three sorts of evidence :—(i) the character and circumstances of the act ; (ii) the criminal's account of the alleged amnesia ; and (iii) his personal and family history.

(i) *Character of the crime.* A criminal act committed in such a condition of disordered consciousness as is likely to be followed by complete or partial defect of memory of the act, is usually marked by absence of any assignable motive, by traits of impaired intelligence in its execution, and by failure of adaptation to its consequences. These characteristics are conspicuous in many epileptic murders, where the murderer kills someone against whom he has no grudge and whom he may never have seen before, when he perpetrates the crime in open day and in the presence of witnesses, when he uses needless violence, battering and mutilating the body of the victim, and when he makes no

intelligent attempt to escape or to conceal the evidence of his guilt. In cases presenting all these features, whether cases of epilepsy or dependent on other morbid conditions, there is, of course, no difficulty in admitting the allegation of amnesia and in inferring the existence of a temporary disorder of consciousness.

But there are other and undoubtedly genuine cases of amnesia in which one or more of these characteristics may be, or may appear to be, absent; there may be a semblance of motive and premeditation when the murderer has a real or fancied grievance against his victim, and has uttered threats with regard to him; the circumstances may be propitious to the act, not through deliberate selection by the criminal, but through chance; conduct during the dream-state, instead of being random and irrational, may have an appearance of co-ordination and consistent purpose; a consciousness of guilt may be suggested by the culprit's running away from the scene of the crime.

In a doubtful case of this kind, a minute scrutiny of the evidence regarding each apparent indication, on the one hand, of lucid consciousness, and, on the other, of disordered consciousness, will frequently justify a probable estimate of its significance. For example, a prolonged series of apparently purposive and well-adapted acts during the supposedly amnesic period will naturally suggest awareness and conscious intent in the criminal, but may nevertheless be quite consistent with the hypothesis of a morbid dream-state; to decide between these alternatives, it is necessary to examine the facts in detail; it may then appear that the elaborate and seemingly intelligent course of action has been inspired by a single directing impulse, and is, therefore, within the known range of possible conduct in conditions of automatism, or, on the contrary, that it shows continuous adaptation to



the consequences, and especially to the remote consequences, arising from the circumstances and criminal character of the acts in question, which would point to the conclusion that consciousness was not obscured and that the allegation of amnesia was false. If a murderer bludgeons a woman to death with a poker which he has had to get from another room, if he then wipes the blood off his hands, closes the street door behind him, goes home to bed, and subsequently asserts that he knows nothing of the crime, it is conceivable, however unlikely, that he may have committed the deed in a state of dream consciousness, though, as we shall point out presently, when complicated series of acts occur in this state, the defect of memory is rarely complete, and there is at all events a blurred impression of what has happened. X

But if our hypothetical murderer, when he fetched the poker, was carrying a more convenient but noisier weapon, such as a revolver, if he took steps which might delay the discovery of the crime by putting the body in a closet and arranging the bed clothes to give an appearance of the victim being asleep, and if he left the house by some unusual way of egress which would diminish the chances of his being observed, then it is obvious that his conduct is incompatible with the theory of a pathological dream-state and that his allegation of amnesia is absurd. In this connection it is also, of course, to be borne in mind that evidences of confused and unintelligent action are frequent in cases of ordinary sane crime, as a result of the criminal's emotional excitement, and need not, therefore, have any pathological significance. X

(ii) *Character of the alleged amnesia.* The account which the criminal gives of his alleged loss of memory has to be controlled by comparison with the details of the crime and with the ascertained facts of clinical experience. This is frequently a somewhat difficult task, for the

available data regarding the characteristics of amnesia in these states of dreamy consciousness are still very inadequate. There are, however, some points sufficiently well established to be used with a certain degree of confidence in judging of the verisimilitude of the criminal's story in doubtful cases. One such point is that the commencement of the amnesic period, and still more its end, are not likely to be sharply defined ; a murderer who is able to fix precisely the moment when he ceased to remember, and the moment when, after going through an elaborate series of actions, he "came to himself," is probably lying, at least so far as this particular point is concerned. On the other hand, at all events in cases where the amnesia is partial and fragmentary, the defect of memory alleged by the criminal may fluctuate to some extent without necessarily implying simulation ; some memories, at first lost, may be revived on cross-examination, or as a result of some accidental stimulus. Again, statements may be made in the dreamy phase with regard to acts committed during this phase, and both the fact and purport of the statements may afterwards lapse wholly from memory.

Instances of this sort—which, of course, are paralleled in the hypnotic state—are rare, but as they may be observed in relation to acts of an indifferent or merely quasi-criminal character, where there is no motive for simulation, their occurrence in connection with homicidal crime cannot be absolutely excluded. The point is of obvious medico-legal importance, as the statements made and subsequently denied or alleged to be forgotten, may be of a kind to imply a knowledge of the criminal act and an apparent motive for it. A conclusion of less assured value, but holding true as a general rule in such transitory neurotic dream-states as we are here considering, is that, if the amnesia is incomplete and patchy, then, other things

being equal, the emotionally keenest impressions are more likely to be retained than the indifferent. When a murderer says that he does not remember the homicidal act, but can recall trivial incidents deep in the alleged dream-phase, there may be some hesitation about accepting the genuineness of his amnesia. This does not, of course, apply to the amnesia associated with the melancholic raptus, where the clouding of consciousness coincides with the acme of the impulsive and emotional disorder, so that it is the memory of the explosive act itself that is most liable to be missing.

It has been suggested that the simulation of amnesia might be detected by association tests, used either simply or with such refinements as the registration of unconscious movements of expression. But, apart from the difficulty that this method requires some amount of co-operation and good-will on the part of the subject, it is obvious that the interpretation of the results must be far too speculative to be of much value; the emotional complex aroused by the stimulus word may not be related to the criminal act at all, but to some other memory, and even if it is related to the act, the emotion may be merely what would be naturally experienced by an individual charged with such an act, whether he had or had not committed it, and if he had committed it whether he had been in a state of disordered consciousness or not.

Further, it has been shown by Löwenstein¹ that, when amnesia has been induced by hypnotic suggestion, the stimulation of the repressed complexes provokes the same emotional reaction as if there were no amnesia; so that, at best, this method could give no help towards differentiating between hysterical and simulated loss of memory. It is conceivable that, under exceptionally favourable

¹ O. Löwenstein, in *Archiv. f. Psych. u. Nervenkrank*, vol. 65, 1922.

conditions, it might be employed as a means of determining whether amnesia was organic (e.g. alcoholic or epileptic) or purely psychogenic, as in malingering and in neurotic repression. It is also possible that in a case of simulated amnesia, when the patient is trying to conceal a conscious or semi-conscious motive by the veiled suggestion of some other motive, his response to stimulus words which touch the real motive may give some indication of its emotional significance in relation to the act. Obs. 38, quoted later in this chapter, may be taken as a case in point.

(iii) *Psychopathological predisposition*. The evidence under this head is of great practical importance, because we possess a considerable mass of fairly well established data regarding the inherited or acquired conditions in which there is a liability to the development of states of dreamy consciousness. We know that they may readily occur in persons who belong to neuropathic and especially to epileptic stocks, in persons with well-marked evidences of chronic alcoholism, in the subjects of head injuries. And we have had abundant evidence of recent years that such phases are apt to occur, and very often to be associated with homicidal crimes, in persons suffering from the neurasthenic disorders induced by war experience. There is also evidence, which has been specially emphasized by Dr. Anderson, of Glasgow, to suggest that a morbid tendency of this sort may be related to malarial infection, developing more readily, of course, in subjects of neuropathic predisposition. And there is some ground for suspecting that recent syphilis may have a similar influence. In any case where amnesia, complete or partial, is alleged with regard to a crime involving a prolonged series of complicated and apparently purposive acts, it is reasonable to expect—though there may be exceptions to the rule—that there should be proof of the existence of one or more of these predisposing factors.

In most of the genuine cases, as we shall see in the illustrative observations summarized below, it is usual to find several such factors in combination. Further, we should expect, though with less insistence, that there should be a history of dreamy states prior to that alleged to have occurred in connection with the incriminating act. Possibly, too, we may find evidence of a morbid intolerance of alcohol, which is a very frequent, though not an absolutely constant accompaniment of this predisposition to transitory eclipses of consciousness. This, it may be remarked, is a point on which further investigation is called for, in order to ascertain how far alcohol tests can be made useful in diagnosis.¹

The value of the several classes of evidence considered in the foregoing remarks, and their bearing on the practical problems of forensic psychiatry, will be brought into view most clearly by reference to a number of concrete cases. For that purpose the following series of observations have been selected as illustrative instances of criminal acts committed, or alleged to have been committed, in phases of disordered consciousness with subsequent amnesia.

Obs. 36. T. T., aged 27, draughtsman. Murdered a man, and attempted to murder two other persons. Patient came of neurotic stock: one of his brothers is in an asylum suffering from typical dementia præcox. Patient himself was said to have been "nervous" in childhood, and to have walked in his sleep and to have wetted his bed till he was about 10 years old. He did well at school, and in his subsequent professional studies, which were interrupted by his joining the Army soon after the outbreak of the war. He served chiefly in India and Mesopotamia, contracting malaria in the latter country. While in the Army his conduct was noted as

¹ Sommer, *Lehrbuch der Psychopath. Ersuchungs-Methoden*, Berlin, 1899.

being at times eccentric ; thus on one occasion he absented himself from duty for several days, and on his return explained casually that he had gone out duck-shooting ; another time, after telling one of his comrades that he was “ fed up ” and “ finished with it,” he handed him a piece of paper, on which he had written a sort of will, bequeathing money and other property which he did not possess ; he seemed subsequently to have no recollection of this incident. After demobilization he got employment as a draughtsman, but was dismissed for incompetence when he had been tried for a few weeks, and failed to find another post.

The circumstances of the murder were these :—About 10 a.m. on the day of the crime he left his lodgings, and, as he was passing a public-house some streets away, he stopped to speak to the manager’s wife who was at the door ; he engaged in conversation with her and her husband, who were acquaintances of his, and told them that he had bought a public-house in another part of the town, suggesting that they might join him in running it. The wife went away while this talk was in progress, but shortly afterwards, hearing a noise, hurried back and found that the patient was hitting her husband on the head with an iron bolt ; he immediately attacked her with the same weapon, and also the servant girl who came to her mistress’s assistance ; he then rushed upstairs to a bedroom, locked the door, and tumbled out the contents of some drawers. The police had now come on the scene, and the patient, after looking out and seeing them in the street, went to a back window and jumped out into the garden about thirty feet below. He was stunned and sustained a fracture of the pelvis. Some hours later, when questioned in the hospital, he professed that his memory was an entire blank from the moment of leaving his lodgings in the morning. The male victim,

who had received nineteen furious blows on the head, died without recovering consciousness ; the wife and servant survived their injuries.

At the trial a defence of epileptic automatism was successfully set up. On admission to the asylum, the patient showed no signs of being mentally abnormal, except that his attitude with regard to the crime and its consequences to himself was strikingly casual and indifferent. He persisted for a time in his allegation of complete amnesia of the events on the day of the murder, but after some weeks stated that a chance word in conversation had revived his memory for the early part of the day, up to the moment immediately preceding the attack on the manager. According to the story which he now told, he awoke with a bad headache, for which he took 15 grains of quinine ; after breakfast he went out to call on a person for whom he was doing a small business commission, and on his way picked up the iron bolt which was lying on his path and which he thought would be useful as a door closer. When he had talked a short time with the manager and his wife they went into the bar and he had a drink with the husband. After the drink he began to tell the story about the purchase of the public-house ; he knew that he was romancing, but could not stop himself. There were more drinks to toast the new enterprise, and patient was taking out some money to pay for his share when he dropped some coins on the floor and stooped to pick them up ; from that moment his mind was a blank except for a vague sense of "struggling." This struggling he thought was vaguely associated with an experience of his war service, when he was on the Indian frontier, and was awakened one night by a false alarm of an attack by the hostile tribesmen ; he was greatly scared, and his struggles with his mosquito net and his rifle which had got entangled in it left a deep

impression on his mind. Repeated examinations failed to elicit any further details or to reveal any variations in his story.

It will be observed that in this case there were a number of possible morbid factors—the original neuropathic taint, the emotional stresses of active service, and the malaria—which might predispose to the development of a phase of dreamy consciousness, especially under the exciting influence of alcohol. Further, the unintelligent character of the crime, and the blind and excessive violence in its execution, would support the theory of a temporary state of obscured consciousness. On the other hand, the patient's conduct after the crime—the locking of the bedroom door, the turning out of the drawers, and the attempt to escape from the police—indicates a degree of co-ordinated action and adjustment to circumstances greater than is usually associated with so complete a state of amnesia as the patient alleges, and would therefore suggest that his story should be viewed with some scepticism, though here again it is necessary to take account of the possible influence of the concussion sustained in jumping from the window, which might obliterate some of the immediately antecedent impressions. If, as is conceivable, in view of the patient's family history and some of the features of the crime, the case is one of incipient or abortive dementia præcox, the hypothesis of a simulated amnesia has also to be borne in mind, for it sometimes happens that a patient in an early stage of that disease will profess to have no recollection of an impulsive crime which he has, in fact, committed with quite lucid consciousness. This is illustrated in the following case.

Obs. 37. E. W., aged 28, mechanic. Murdered his sweetheart and attempted suicide. There was a history of insanity in the patient's family, but he had not himself

shown any signs of abnormality in childhood, at school, or during the period of his technical training. For some time before the murder, however, he had been noticed to be strange in manner, had suffered much from headache, and had expressed fears of going "dotty." His relations with his fiancée had become strained, but there was no actual rupture, though they had quarrelled owing to his jealous suspicions. He went to her house one morning, found her alone, cut her throat and attempted suicide with the same weapon. On arrest, he seemed to be mentally confused, and remained so for some hours. On recovering from this condition he professed to have no memory whatever for the preceding three days. Some rambling letters which he had written before the murder and within the period of alleged amnesia supported his plea of irresponsibility.

On admission to the asylum he at first adhered to his story of entire loss of memory, but subsequently admitted a vague and partial recollection of incidents preceding the crime. For a little over two years he showed no signs of mental disorder, was cheerful, rational and industrious. Then rather suddenly he became depressed, complained of "funny feelings," and had a slight pseudo-epileptic seizure. He now spontaneously wrote out a full and clear account of the murder, describing with characteristic minuteness the feeling of compulsion under which he acted at the time, as shown in the following sample passage from his statement:—"I got up on Wednesday morning to go to work but I was told not to go by some unknown power. I was told to go to her house. My intentions on my journey up there were to go to my doctor's but I did not do so. I went straight to her house. When I got to —— Road I thought I saw S—— and A—— [two friends] on their bikes. I shouted to them but they would not answer. I turned back and went to the house.

. . . It was as though I could not break from doing it." Symptoms of typical dementia præcox developed rapidly in the next few months; the patient became mentally enfeebled and resistive, refused food, made sudden impulsive attacks on other patients, and sudden silly attempts to commit suicide, complained of electricity in his body, said that he was bloodless, that his veins had been taken away, etc.

The following observation illustrates, *inter alia*, the general rule that, where conduct in the dream-phase shows a high degree of co-ordination and apparent purpose, and especially where there is evidence of adjustment to changing conditions, the amnesia is only partial and fragmentary.

Obs. 38. A. C., aged 24, labourer. Murdered his sweetheart by strangling her. Prisoner's sister committed suicide while suffering from "religious mania." His personal history during childhood and youth did not present anything of note. Enlisting in the Army shortly before the outbreak of the European War, he saw active service on the Flanders front, where, after being twice wounded, he broke down with neurasthenia; recovering after a brief period of hospital treatment, he was transferred to the R.A.M.C., and served at Salonica, where he contracted malaria. He was eventually demobilized with a small pension two months before the murder. In the interim he was twice picked up in the street in a confusional condition, attributed by medical men who saw him at the time to attacks of *petit mal*. On the second of these occasions, which was the day preceding the murder, he told a story of having fallen in a "malarial fit" and been robbed of a large sum of money which he had just drawn as back pay. He had not, in fact, drawn any money, nor was any back pay due to him. He had been engaged to his victim for about a year, but his

family disliked the girl, and there were numerous quarrels over the affair, especially arising from stories which his sister told of the fiancée's flirtations with another man.

On the afternoon of the day of the murder, the girl came to his house, and there was a violent scene between her and the patient's mother and sister, which ended in the girl leaving the house, followed by the patient. About 2 p.m. on the following day the patient stopped a cyclist on the road near a country inn in the vicinity of the town, asking him, if he should meet a policeman, to send him to the scene, as there was a body lying in the wood. He showed him the place where the corpse of a woman, naked except for a coat buttoned over the chest, was lying on the grass; the corsets and underclothing were in a bundle a few yards from the body. The patient promised to stay by the dead woman until the cyclist fetched a policeman, but on their return he had disappeared. A few minutes after 9 p.m. the same evening, the patient accosted a policeman in a suburb of the town, asked the way to the police station, and said, "I done it last night," adding, on his way to the station, "She got two packets of salts of lemon from X—— the chemist's yesterday."

At the station he told the police that he and the girl had walked to the inn near which the body was found; they had some drinks together; he stayed behind her a few minutes to settle the account, and on coming out found her trying to vomit; she ran into the wood, and he followed her; she said that she had taken salts of lemon; she was foaming at the mouth; she pulled off her clothes and squeezed her belly to relieve the pain; he then lost his head, and, with the idea of putting her out of her misery, choked her. He alleged that he had no memory of anything from that moment till about 7 a.m. the next day, when he found himself in a village near the inn; there he wrote and posted cards to his

mother and the girl's mother, intimating that he and the girl had agreed to commit suicide. He had a vague recollection after that of going back to the body and packing the clothes up ; then his memory lapsed again till he surrendered to the police. The story of a suicide compact was supported by a letter found in the girl's pocket, hinting at some such idea. There was, however, no trace of irritant poison found, and the story of the purchase of the salts of lemon was disproved. There was evidence of recent coitus having taken place.

While awaiting trial, and after admission to the asylum, the patient gave substantially the same account of the affair as he told the police, though varying somewhat in the details of the story, especially as to the extent to which he could recall incidents in the fugue following the murder. He persisted in his statements about the salts of lemon and about his sudden impulse to choke the girl in order to shorten her sufferings. He repudiated any suggestions that he was jealous, and he strenuously denied that there had been coitus just before the murder. Association tests showed marked emotionalism, slow reaction, and failure to reproduce, when stimulus words were used which might refer to the stories of the girl's infidelity or to the contrast between his own slight physique and the better build of his supposed rival. Thus, in contrast with his responses to indifferent words, which were of ordinary type, and showed an average reaction time of 2 secs., the following exceptional results appeared :—Trouble . . . speaking, 6 secs. (on repetition, trouble . . . speaking, 3 secs.) ; Man . . . grown person, 6 secs. (on repetition, man . . . male, 3 secs.) ; Short (patient is of very low stature, the rival is tall) . . . no response, but patient becomes flushed and complains of giddiness.

Some two months after admission, he professed to have

a clearer memory of the crime, and told a somewhat different story ; while adhering to the statement about the salts of lemon, he now said that he and the girl had a good many drinks at the inn, enough to make them a bit mixed, that she ran into the wood, he followed her, she pulled some of her clothes off, they had connection, and he strangled her in the act. He could offer no explanation of his previous reticence on this point, nor did he attempt to reconcile the episode with the girl's alleged agonies from the effect of the poison. With regard to his supposed loss of memory of his proceedings after the crime, he repeated the same story as before. He was anxious to insist on the factors of malaria and drink, and to repudiate the suggestion of epilepsy, having, doubtless, learned from other patients that it might be to his prejudice in the future to be suspected of an epileptic tendency.

While the obvious element of lying in the whole story renders it difficult to form any assured conclusion as to the facts of the case, the balance of probabilities seems to incline to the view that the crime was committed in a confusional state, developed under the influence of alcohol in a neurotic subject whose instability was aggravated by the stress of emotional conflict through family disputes and suspicions of the girl's infidelity. The sudden emergence of the homicidal impulse after coitus would be in accord with clinical experience in such morbid conditions, as is illustrated in the following typical observation :

Obs. 39. H. F., aged 19, artisan. Murdered his wife by strangling her. A sister of the patient died of convulsions in childhood, and a cousin is in an institution for mental defectives. Patient himself sustained a head injury in infancy, and at the age of 16 began to suffer from occasional "fits," which did not, however, present any unequivocally epileptic characters. He had been

married only a few months before the murder, and had indulged excessively in sexual intercourse. On the evening of the crime the patient and his wife were alone ; they were seen together, apparently on their ordinary affectionate terms, at about 8.30 p.m. Half an hour later the patient came out of the house, holding a poison bottle to his lips, and said to the next-door neighbour, " My wife is dead. I have taken salts of lemon." The woman was found dead, lying on her back in the bed, with bruises on the neck indicating that she had been throttled by pressure on the larynx exercised by the fingers and thumb of the murderer's right hand. There were no signs of a struggle. The patient's story was that he had connection with his wife, after which he remained beside her with his left arm round her waist ; that the next thing he remembered was finding himself lying at the foot of the bed, feeling dazed ; that he spoke to his wife, and on getting no reply, jumped up and discovered that she was dead and that he had apparently killed her ; that he then took the bottle of spirits of salt, which was on a shelf in the room, drank its contents, and rushed out of the house. The terms on which the patient lived with his wife, the absence of any evidence of struggle, and the fact that the throttling was done with the right hand only, were fully consistent with the patient's statements, to which he steadily adhered. It seems, therefore, reasonable to conclude that the crime was due to a homicidal impulse in a state of clouded consciousness, such as might readily develop in a subject with the patient's morbid predisposition.

While proof of the existence of some adequate predisposing cause is usually forthcoming in genuine cases of alleged temporary clouding of consciousness with amnesia, it has to be recognized that the absence of such proof is not of itself sufficient to warrant the rejection of this plea.

Though it is probably a very rare event, it does sometimes happen that a transitory disorder of this kind may occur in an individual in whose family history and personal antecedents no evidence can be found of any of the morbid conditions which are ordinarily related to the development of states of dreamy consciousness. In cases of homicidal crime, the interested motives which are generally present will naturally tend to make the culprit's story somewhat suspect; and on that account it will be preferable to illustrate the point in question by reference to an instance of indifferent and quasi-criminal conduct, as in the following observation:—

Obs. 40. J. T., aged 54, gardener. Convicted of malicious damage to a fire-alarm. From the police evidence it appeared that the firemen, going in response to a call to an alarm station, found the prisoner seated beside the alarm in a dazed condition, unable or unwilling to give any account of his conduct. On reception into prison some twelve hours later, the man was a little confused as to time and place, spoke with some difficulty of articulation, and showed a marked tendency to use periphrasis. He said that he did not know why he broke the fire-alarm, that he “was afraid of something.” He answered questions with some slowness, but frankly and relevantly. Gait, writing, etc., were normal, as was also the state of the reflexes. There were no signs of recent drinking and no signs of chronic alcoholism. After a night's rest he was much clearer, but still appeared slightly aphasic, e.g. had some difficulty in naming familiar plants in the garden.

A few days later he seemed practically normal, except that he complained still of some difficulty in articulation and of some fatigue in continued thought. Examination of the nervous system failed to show any objective signs of disorder. The bodily organs were healthy, but there

was some rigidity of the palpable arteries. So far as could be ascertained, there was no insane or epileptic taint in his family history. The man himself bore an excellent character ; he was temperate, a skilled gardener, and always in regular work. He said that he had never had any serious illness, and certainly never had any previous attack of this sort. With regard to his movements on the day of the affair, he stated that he remembered quite clearly going in the morning to get his instructions from the nurseryman for whom he worked, and, in accordance with these instructions, going in the afternoon to the flower-market. From that time he had no recollection till he found himself in the police van on his way to prison, and asked where he was and how he came to be in custody. In the period of obscured consciousness, which lasted about twenty-four hours, he could just remember the act of breaking the fire-alarm ; he could not give the time or place of the occurrence, and was not even sure whether it was day or night ; he could only remember that, as he broke the glass, he had a feeling that " something was going to happen," that he would be safe if someone came, and that he saw a man in a brass helmet running towards him. Before and after that his memory was a blank.

Had the impulsive act in this case been a homicidal act, as it might easily have been, the story of temporary mental confusion with amnesia would probably have been regarded with some scepticism, in view of the absence of any plausible ground for supposing an abnormality of constitution, inherited or acquired. Inasmuch, however, as the man had committed an act of little more than technical criminality, and had, moreover, purged his offence, such as it was, by serving his short term of imprisonment, he had no conceivable motive for lying. Further, it will be noted that the account which he gave

of the alleged dream-state was fully consistent with clinical experience, as instanced, in particular, by the fact that the one incident in this state which he was able to remember was the impulsive act at the moment of highest emotional tension. Cases of this sort appear to be very exceptional, and, when associated with seriously criminal conduct, they obviously require much critical scrutiny before their genuineness can be admitted. In such circumstances, the details of the alleged amnesia, and the presence or absence of an intelligible motive for the crime, become the most important points for consideration.

CHAPTER XI

CRIME IN RELATION TO HYSTERIA

The wide divergence of opinion which has always existed, and exists to-day no less than in the past, regarding the nature and limitations of hysteria, may be allowed to justify, and indeed to compel, the avoidance of any attempt to define this morbid condition. It will be enough for our purpose to proceed on the provisional assumption that it is a psycho-neurosis depending on an original anomaly of constitution, and characterized by a variety of symptoms arising from emotional repression. The repressed emotions, at all events in the graver cases of hysterical crime, are almost always related to the sexual instinct, and in most instances the acts can be traced to this source without much difficulty, though the connection may at times be by somewhat devious ways.

The criminal conduct associated with hysteria usually exhibits the fantastic and histrionic character which belongs to the disorder in all its manifestations. The hysterical servant-girl who purloins her employer's property may be found gagged and tied to a chair, and will tell a circumstantial story of having been attacked and overpowered by masked burglars. Frequently she will arrange the same dramatic scene, and will tell the same thrilling story, even when she has committed no theft, or has only hidden some valuables to give colour to her romance. The same desire to excite interest and acquire notoriety will also prompt the hysteric to real

or simulated attempts at arson, often repeated several times within a few days, so as to heighten the effect of mystery. Exploits of this kind may also be designed to throw suspicion on other persons, against whom the culprit has a grudge arising out of sexual disappointment or jealousy. And similar malignant motives usually inspire what are perhaps the most characteristic forms of hysterical crime—the false accusations of sexual assault, and the writing of anonymous letters imputing sexual misconduct to innocent persons.

In carrying out slanderous campaigns of this latter kind, hysterical women frequently show a very remarkable degree of perverted ingenuity, giving a semblance of truth to their myths by blending real details of a trivial sort with their lying stories, by devising means of inveigling their intended victims into situations which may be made to look compromising, and by concealing their authorship of libellous letters, not only by skilful disguise of handwriting, but also by inducing dupes to post such letters in places or under conditions which may divert suspicion from the real culprit. One such patient, for instance, who had imposed on a clergyman by pietistic professions, and had got him to interview her alone in his church, accused him, after the usual hysterical way, of drugging her with a doped cigarette and assaulting her while she was unconscious: she circulated this story amongst his friends and ecclesiastical superiors by letters over false signatures, and, when charged with the offence, managed to arrange, before her arrest, for the posting of similar missives while she was in prison.

Occasionally the crimes which neuropaths of this class commit in order to satisfy their vindictiveness, or to further in some indirect way their amorous ambitions, are of an even graver character; and there are several instances on record of reckless and indiscriminate poison-

ing perpetrated with this aim. The following case, which attracted a good deal of public attention at the time of its occurrence, illustrates very strikingly this type of hysterical murder:—

Obs. 41. C. E., aged 43, unmarried. Poisoned a child with strychnine which she had put into sweets in a confectioner's shop. The patient came of a very insane family; her father died in an asylum; her brother was an epileptic imbecile; her sister suffered from hysterical convulsions and had attempted suicide; there was also evidence of insanity in earlier generations on the maternal side. The patient herself was flighty and unstable as a child, and for several years was subject to somnambulism. When she was 25 years of age, she suffered from hysterical fits and paralysis. Some eighteen months before the murder, she made the acquaintance of a doctor, and, imagining that he was in love with her, and that he would marry her if he were free, she tried to poison his wife with strychnine given in chocolate creams. Though her guilt was not proved at the time, the strong suspicions attaching to her led to the breaking off of the acquaintance. It was apparently in consequence of this frustration of her hopes, and with a view to rehabilitating herself in the eyes of the fancied lover, that she embarked immediately afterwards on her extraordinary career of crime.

Under an assumed name and by plausible forgeries, she obtained a quantity of strychnine from a chemist. Accosting a small boy in the street, she sent him to buy her some chocolate creams at the shop where she had got the sweets with which she had tried to poison the doctor's wife. When the boy brought the packet to her, she opened it, and, saying that the chocolates were too large, sent him back to change them, substituting for the original creams others into which she had put strychnine.

nine. These were naturally returned to the stock in the shop, and one of them being eaten by a child, caused his death. No evidence was forthcoming as to how the strychnine got into the sweets, and the coroner's inquest exonerated the confectioner from any blame for negligence. The patient volunteered to give evidence at the inquest, and testified that she and her friends had been ill after taking sweets purchased at the same shop. When the inquiry was closed, she tried to work up feeling against the confectioner by repeating the same statements, and by sending anonymous letters to the victim's father, inciting him to take proceedings against the shop-keeper.

These activities on her part, and the fact that she gave sweets to several children, some of whom got ill after eating them, put the police on her track, and led to the discovery of her purchases of strychnine, and her manoeuvres to introduce the poisoned chocolates into the confectioner's stock. During the period of her asylum detention, the patient showed an entire absence of moral sensibility, with marked evidences of hysterical temper and an extraordinary degree of morbid vanity and coquettishness, but without any failure of intelligence.

In other instances of hysterical murder, though the connection between the crime and its sexual motive may seem no less remote and indirect, the act itself may be committed without any such display of cunning as was shown by the patient in the above case, and even, as in the following observation, without any effort at all to evade detection.

Obs. 42. M. M., aged 35, housekeeper, unmarried. Murdered her employer's child by drowning. There was nothing of note in what could be ascertained of the patient's family history. She herself had been capricious

and fanciful from childhood, and, as she grew up, developed an increasingly hysterical temper, which made her insupportable in her home. She took a morbidly intense interest in religious and sexual matters, indulging in pietistic practices and constantly dwelling on the impurity of the world and the dangers to which female virtue was exposed from the lusts of the male. At this time she began to suffer from occasional attacks of nervous vomiting, which recurred at various times throughout her life, and were apparently connected with pregnancy phantasies.

After some years' intermittent work at dressmaking, her peculiarities of temper and her quarrels with her mother and sisters led her family to try to get rid of her by emigrating her to Canada, but the aggravated symptoms of mental instability which she manifested on her arrival there caused the port authorities to refuse her admission. For some years after this she remained at home, with intervals of employment as nurse and housekeeper, each post of this sort being given up after a short time, usually, according to her story, on account of the improper advances made to her by her employers or their male relatives. In her last place, where she was housekeeper to a widower and looked after his little girl, she made a longer stay, but with occasional quarrels, in one of which she cut up the clothes of her employer and of his two grown-up nephews who lived with him. This freak she explained subsequently as a protest against their impurity, and an act "to teach all men that a woman's honour is her all." It was soon after this affair that she drowned the child in a bath. She avowed the crime at once, alleging that her motive was to save the girl from growing up to encounter the evil and immorality of "a man-made world."

For some time after the murder she was dull and

depressed, refused to answer questions, and affected an extreme childishness of manner. These symptoms disappeared within a very short time of her admission to the asylum, and she then alleged that they had been assumed, referring sarcastically to the Judge and jury who had tried her—"Poor things, I did pity them, too. . . . I made them all believe I was insane from beginning to end just to save them from themselves. I knew what I was doing. . . . The poor child was best out of it."

Association tests and the record of the patient's dreams showed clearly the dominant influence of a strong father-complex—e.g. all her slow and unusual responses were reactions to test words which she connected with scenes of close companionship with her father, and his physical attributes were identical with those of the Deity and of the human beings who figured prominently and advantageously, often with unmistakable phallic imagery, in her very vivid dreams. She suffered occasionally, and especially after conversations about her father, from functional deafness, apparently related to a substitution phantasy, patient's mother being very deaf. Her failure to remain in her earlier places seemed to be due to the desire to get back to the society of her father. In her last situation, which she entered after his death, she settled down better, and there were some indications that she was disposed to transfer to her employer the emotional interest which she had previously attached to her father. The killing of the child may thus have been a means of gratifying the patient's ill-feeling against its unresponsive parent, as well as an emphatic assertion of the obsession of purity resulting from the repressed sexual complex.

Crimes of hysterical origin are very apt to be committed by girls about the time of puberty, and may take

the form of murder, or, more frequently, as in the following observation, of arson.

Obs. 43. M. T., aged 17, general servant. Information regarding the family history was scanty. The patient herself did not show any obvious signs of abnormality until about a year prior to the crime, when, coincident with the onset of menstruation, she became flighty, irritable, and morose, and began to suffer from "fits." She was domestic servant in the house of an actress, who was understudying a leading part in one of Rheinhardt's spectacular productions, and in her fits, which bore a striking resemblance to the so-called hysteropilepsy of Charcot and Richet, the patient would reproduce, in the phase of *attitudes passionelles*, the complete repertory of her mistress.

The circumstances of the crime were these :—On three occasions, two of which were on the same day, carpets and furniture were found alight in different rooms in the house, in positions where it was conceivable that they might have been reached by sparks from the fire. The occurrence of these accidents so close together, and the patient's excess of zeal in explaining how easily they might have come about, threw suspicion on her, and she was interrogated by the police. At first she protested her innocence, but later on, in consequences, she alleged, of threats and promises, she admitted that she had set fire to the things. When formally charged, she repudiated this confession, and had a series of fits, which recurred each time she was brought into the presence of the officer who, according to her story, had frightened her into the false avowal of guilt. In the asylum she maintained this attitude for a time, taking refuge in fits whenever she was questioned too closely on the matter. Eventually she acknowledged that she had committed the acts, and explained that her motive

was to obtain the insurance-money for her mistress, to whom she was extravagantly attached. The fits, which occurred usually at her menstrual periods, and were apparently connected with onanism, gradually became less frequent, and, after a couple of years, she attained a quite normal degree of stability.

Similar instances of temporary hysterical conditions leading to criminal acts, generally of a comparatively trivial sort, are not infrequent in women about the time of the menopause. Shop-lifting, for example, is a fairly common form of delinquency at this epoch, and in many cases seems to be a symbolic manifestation of a repressed sexual complex.

Hysterical crime is much rarer in men, but some instances of impulsive acts in transitory dream-states with following amnesia, which were discussed in Chapter X, are probably to be regarded as being, at all events to some extent, of this nature. And one tolerably common form of delinquency—indecent exposure or exhibitionism—is very often associated with evidences of hysteria. Exhibitionists are usually confirmed masturbators, and their morbid tendency, like the homicidal impulses which sometimes develop in adolescents addicted to the same habit, may possibly have a sadist element. This is suggested by the fact that the gratification arising from the act is experienced only when exposure is before respectable women, who may be frightened or offended, and never before prostitutes, nor, unless the exhibitionist is an invert, before boys or men. The hysterical temperament of these offenders makes them very susceptible to suggestion, and, some years ago, when they were the object of special attention from alienists, it was fashionable to describe them as suffering from an obsession *sui generis*, with distinctive nervous symptoms. As exhibitionism was not so minutely studied in this country,

these symptoms were rarely observed. In an extensive series of cases, I found them only in one patient, and he had worked as a printer in the office of a French psychiatric journal, where he had learned what he ought to experience in connection with his morbid impulses. The present-day exhibitionist suffers from mental conflicts.

From the egoism and the lack of ethical sensibility which are common in hysteria, the condition often bears a close resemblance to moral imbecility ; and in many instances, especially in cases of pathological swindling and blackmailing, the distinction can hardly be made.

CHAPTER XII

CRIME IN RELATION TO CONGENITAL MENTAL DEFICIENCY

In the preceding chapters we have discussed, in relation to the phenomena of criminal conduct, the various clinical conditions arising from decay or disorder of mind. We have now to consider, from the same point of view, the manifestations of mental inadequacy which depend, not on impairment of psychic function, but on its imperfect development.

From the earliest times that insanity has been the object of observation and inquiry, a distinction has been recognized between these two kinds of unsoundness of mind, between states of acquired mental disorder and states of congenital mental deficiency, or, to use the language of the jurists, between *dementia adventitia* and *dementia naturalis*. The degree of such original deficiency will, of course, differ according to the stage at which the process of development undergoes arrest, so that we find a regular gradation of feebleness of mind from conditions of extreme idiocy to conditions of slight subnormality. These differences in the amount of mental endowment provide an obvious means of classifying cases of congenital deficiency, and it is, in fact, on this basis that it has always been customary to distinguish the three categories of idiots, imbeciles, and feeble-minded. The distinction between these several groups and between the highest of them and the lowest grade

of the normal being merely one of degree, the lines of demarcation are, of course, arbitrary ; but, as they are laid down on generally agreed principles and with reference to fairly positive criteria, they enable the several groups to be defined with considerable precision. This applies, at all events, to the differentiation of the groups in respect of intellectual capacity, which, thanks to the method of measuring intelligence devised by the distinguished French psychologist, Binet, can now be estimated with approximate accuracy.

Binet's original system, which has been modified, but not appreciably improved, by later investigators, was worked out in collaboration with Dr. Simon, and is currently known as the Binet-Simon method.¹ It is based on the measurement, by a series of empirical tests, of the average intelligence of normal children at different ages. By comparison with the scale of intelligence found in this way, the mental development of a defective subject can be readily determined and expressed in terms of intellectual age. Thus, a defective who, at the age of 20, succeeds only in the tests which can be performed by the average normal child of 8, is described as having an intellectual level of 8 years.

Measured on this scale, the three categories into which mental defectives have been immemorially divided, were defined by Binet as corresponding to the following intellectual levels—idiots, up to the intelligence age of 2 years ; imbeciles, from 2 to 7 years ; feeble-minded persons, or morons, from 7 to 12 years. And these estimates are found in practice to harmonize very well with the rougher definitions, based on the capacity of social adaptation, which have been laid down in the Mental Deficiency Act of 1913 :—“(a) Idiots, that is to say,

¹ A. Binet and T. H. Simon, in *L'Année Psychologique*, vols. 15, 16, 17, 1909–11.

persons so deeply defective in mind from birth or from an early age as to be unable to guard themselves against common physical dangers. (b) Imbeciles, that is to say, persons in whose case there exists from birth, or from an early age, mental defectiveness not amounting to idiocy, yet so pronounced that they are incapable of managing themselves or their affairs, or, in the case of children, of being taught to do so. (c) Feeble-minded persons, that is to say, persons in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision, and control for their own protection or the protection of others, or, in the case of children, are incapable of receiving proper benefit from instruction in ordinary schools."

Congenital mental deficiency is not, of course, confined to the sphere of the intelligence; it may involve also the emotions and the will; but, as we have as yet no means of measuring these aspects of psychic activity, it is impossible to estimate with the same exactness the degrees to which their development may depart from the normal. Neither can we by any means assume that intellectual defect implies an accompanying emotional and volitional defect of like degree. No doubt, in many cases this is so, but very frequently there is no sort of correspondence between them, and a low level of intellectual capacity may be associated with a high degree of moral sensibility; or, conversely, a marked degree of affective debility may coexist with very little evidence of intellectual weakness, as in so-called moral imbecility. This latter condition, which is recognized in the Mental Deficiency Act as a special form of congenital defect, will be discussed in a separate chapter.

Confining our view for the moment to cases of predominantly intellectual defect, we have to consider the

relation to crime of imbecility and feeble-mindedness, for the idiot, from the poverty of his aptitudes, is obviously as incapable of anti-social as of social conduct.

That mental defect involves some degree of predisposition to crime has been inferred from the universally recognized fact that the proportion of weak-minded persons is considerably higher amongst convicted criminals than it is in the general population. In this country, for example, it has been estimated that from 5 to 15 in even 20 per cent. of the inmates of prisons are mentally defective, while in the general population the proportion is supposed to be only about .5 per cent. These estimates, it is true, are arrived at by rather rough and ready methods, and their accuracy is not to be rated too highly. Moreover, the prison population is not representative of criminals as a class, but only of convicted criminals, and mental deficiency, if it predisposes to crime, predisposes even more to detection. Still, when due allowance has been made for these qualifying considerations, it remains beyond doubt that mental defect is far more frequent amongst offenders in the mass than in the law-abiding population, and the inference that such defect predisposes to breaches of the law is, to that extent, valid.

But, as was pointed out in Chapter II, crime is too comprehensive a term to convey any clear meaning in this connection until it has been considered in its qualitative aspect; and accordingly, before the criminal proclivities of the feeble-minded are assessed at the high rate which the above-quoted figures would suggest, it is necessary to examine more closely the character of their delinquency. When this is done, it is found, as might indeed be anticipated, that the offences which such persons are most prone to commit, are very largely of a minor and quasi-criminal kind—for instance, begging,

sleeping out, soliciting for prostitution, petty larceny, and the like. This predominance of trivial forms of delinquency is, of course, a natural result of the mental disability of the weak-minded offender; skilled crimes and crimes that demand intelligent combination and prevision are quite beyond his mental capacity. Even in the case of the crude and impulsive crimes which these defectives most frequently commit, a clear correspondence is traceable between the intellectual level of the offenders and the complexity of their criminal acts. Thus Dr. F. C. Shrubsall,¹ in a recent paper on this subject, has shown, by a calculation of the mental ages of a number of weak-minded adult offenders, classified according to the nature of their offences, that the average level of intelligence is sensibly higher in cases of theft than in cases of begging, in cases of indecent assault than in cases of indecent exposure.

Similarly, in the case of the graver forms of criminality, it is found that the offences of the congenitally weak-minded are largely restricted to the cruder and more impulsive sorts of crime. This point is illustrated by the following Table VII, from Dr. Goring's study of the English convict, showing the percentage of mental defectives in relation to the character of the crime in a population of 948 convicts. It will be seen from this diagram that amongst criminals convicted of the more skilled offences, such as embezzlement and forgery—offences which, for the most part, imply intelligence and education—there are no defectives; that the percentage of the weak-minded rises regularly with the decreasing complexity of the offence, being higher in thieves and burglars than in coiners and receivers, higher in sexual assaults on children than in the same class of offence

¹ Shrubsall, in *British Journal of Med. Psychology*, vol. 3, part 3, 1923.

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TABLE VII

PERCENTAGE OF MENTAL DEFECTIVES AMONGST PERSONS
COMMITTING CRIMINAL OFFENCES

Per cent.	
Firing of stack . . .	52.9
Wilful damage, including maiming of animals . . .	22.2
Arson	16.7
Rape (child) . . .	15.8
Robbery with violence	15.6
Unnatural (sexual) offences . . .	14.3
Blackmail	14.3
Fraud	12.8
Stealing (and poaching).	11.2
Burglary	10.0
Murder and murderous intent . . .	9.5
Rape (adult) . . .	6.7
Receiving	5.1
Manslaughter.	5.0
Coining	3.3
Wounding, intent to wound, striking superior officer . . .	2.9
Embezzlements, forgery, fraud . . .	0.0

against adults; and that it reaches its height in the typically easy and simple crime of stack-firing. It should be noted that these figures refer to the population of a prison where weak-minded convicts are specially

segregated, so that the percentages of mental defectives recorded are excessive, and are not, of course, to be taken as indicating any corresponding incidence of mental deficiency on these several categories of offenders in general; they merely show in a rough manner the limited scope of the graver anti-social activities of the mentally defective.

It may be remarked here that the question of the degree of mental debility as affecting the range of criminal conduct may sometimes be an important element in judging whether a feeble-minded person, accused of crime, is guilty or innocent of the material facts imputed to him. The following case illustrates this point:—

Obs. 44. J. B., aged 16. Charged with setting fire to a haystack. The stack was in a field of growing corn, and was about 40 yards from a road on the other side of which was a village recreation ground. The accused and a number of other boys were in this recreation ground on the evening when the fire occurred. A woman walking on the road gave evidence that, just before the fire was noticed, she saw the boy cross the road into the field and return after a few minutes. According to the police evidence, the accused, when charged with the offence, first said, "Me not set the stack on fire." Asked what he was doing in the field, he replied, "Me went behind the stack to make water, me then went into the cricket-field and told the fellows the stack was on fire." After further questioning, he said, "Me lit it with match found on road, then tried to pittle it out." For the defence, some of the boy's companions swore that he had been with them in the cricket-field all the time. The accused, who had sustained a severe head injury at the age of $2\frac{1}{2}$ years, was well known throughout the district as a harmless imbecile. On examination by the Binet-Simon tests, he was found to have an intelligence level under

6 years ; his vocabulary was extremely poor and simple. It would obviously be beyond the capacity of an imbecile of this grade to carry out the complicated series of acts involved in the theory of the prosecution as to the manner in which the crime was committed and the tracks of the criminal covered, nor could he possibly have constructed the elaborate phrase ascribed to him in his supposed confession.

Of course, many crimes of a very grave character need not involve any great complexity of conduct in their execution, and so may be well within the capacity of the imbecile. Sometimes he will commit such offences from mere inability to realize the consequences of his conduct—as, for example, when he sets fire to a haystack just for the pleasure of seeing a blaze, or when he kills a child in imitation of his mother killing chickens. And when he reaches puberty, his lack of inhibitory control will make him prone to crimes of lust, which are, in fact, amongst the most frequent of the graver offences of defectives of all grades. The following case shows the characteristics of imbecile criminality in its grossest form :—

Obs. 45. T. C., aged 29, farm labourer. Outraged and murdered a child. The patient was a congenital defective, but had been fairly tractable up to the age of puberty, when he developed strong sexual cravings and was frequently irritable and vindictive. He had not, however, shown any definite signs of being dangerous prior to the crime. The circumstances of the murder were these :—He enticed a little boy and a little girl of his acquaintance to accompany him to a lonely place on the farm where he worked ; he pushed the boy into a stream, and took the girl away. On the boy making his way home some time after and telling what had happened, the patient was sought for by the police, and was found

locked in the bedroom which he occupied in the house of his parents. Asked where the girl was, he at once led the policemen to the spot where he had committed the crime; the child had been raped and strangled. On admission to the asylum, the patient professed to have only a vague memory of the murder, saying that he had had drink and did not know what he was doing. This fiction, and his reluctance to talk about the crime, were the only indications he gave of appreciating in the least the enormity of his conduct. His intelligence level measured on the Binet-Simon scale, was between 5 and 6 years.

With degrees of mental defect not amounting to imbecility, the aptitudes for more complicated acts allow of a larger variety of anti-social conduct, and it is found, accordingly, that the criminality of morons, and especially of higher grade morons, is more frequent, and approximates more in character to that of the ordinary delinquent. Morons have also, of course, a better appreciation than imbeciles of the nature of their misconduct, at all events to the extent that they partly realize its possible consequences to themselves. It should be noted, however, that this qualified capacity of appreciation may tend to aggravate rather than to diminish the danger of their criminal proclivities. Thus a feeble-minded person who robs or commits a sexual assault on a child, may be led, by his recognition of the punishment he may incur, to prevent denunciation by murdering his victim. And he will be more prone to do this because his lack of critical judgment will make him confident of his ability to conceal his guilt by fantastic lying.

In these higher grade morons, intellectual defect is a less important element in anti-social conduct than is weakness of inhibitory control and lack of moral sensibility, so that the character of their delinquency

approaches very closely to that of the moral imbeciles, and does not call for separate consideration. In fact, as we shall see in the next chapter, when treating of moral imbecility, the differentiation of the two classes can be made only in an arbitrary way according to the relative predominance, on the one hand, of intellectual debility, and, on the other, of affective and volitional abnormality.

CHAPTER XIII

CRIME IN RELATION TO MORAL IMBECILITY

The Mental Deficiency Act of 1913 recognizes, in addition to the three classes of defectives discussed in the last chapter, a fourth class under the title of "moral imbeciles," who are defined by the statute as "persons who from an early age display some permanent mental defect coupled with strong, vicious or criminal propensities on which punishment has had little or no deterrent effect." The terms of this definition, and the assumptions implicit in it, will be examined in detail later on; for the moment it will be sufficient to quote it as indicating in a general way the group of criminals who are to be considered in the present chapter. And, as there is much divergence of opinion regarding the nature and origin of the abnormality of constitution which is presumed to underlie the anti-social conduct of these criminals, it will be most convenient, before discussing the problem of moral imbecility in its theoretical aspects, to illustrate the clinical characters of the condition by a number of concrete instances. The following selection of cases will give a fairly adequate idea of the type of delinquents whose aberrations of conduct would be set down, according to current usage, to the account of moral imbecility.

Obs. 46. G. B., aged 51, labourer. Patient is the eldest of a family of eight children, of whom three others have survived to adult life, and are said to be normal; a paternal aunt was insane, but there is no other evidence

of nervous taint in the family history. From childhood the patient was exceptionally troublesome and destructive—ill-treated the younger children, broke up the furniture in fits of rage, stole money from his parents. He was also very refractory at school, and was slow in learning. He wet the bed up to 9 years of age. On leaving school he got employment as a vanguard, but was soon dismissed for thieving. After a second conviction for larceny, he joined the Navy, and was discharged after he had served five months. From that time on his life was passed in prisons, workhouses, and lunatic asylums. || His criminal offences were of a very varied type, comprising drunkenness, larceny, housebreaking, wilful damage, attempted suicide, indecent exposure, frauds.

Many of his exploits were evidently inspired in the main by a desire to gain notoriety; for instance, one of his ways of indecent exposure was to secrete himself in a first-class carriage in a train running into a Metropolitan terminus, to throw his clothes out of the window, and to emerge naked on a crowded platform. He was also in the habit of giving himself up for any murder that happened at the time to be engaging public attention. In his housebreaking expeditions, besides stealing articles of value, he made a practice of doing all the mischief he could, turning on the water-taps, for instance, and cutting the gas-pipes. He was highly pleased when his performances got into the papers, and carefully preserved the press-cuttings. He took much interest in the question of criminal responsibility, reading up the subject in the public libraries, and discussing his own legal position. In one of his letters he argued in detail the case for his full responsibility, under the McNaughten test, on the ground that "I never do anything amiss to what I know I am doing of, and I can answer questions to that effect. Asylum doctors says I have a knowledge of right and

wrong." The patient is physically ill-developed, with asymmetrical face, retreating forehead, and misshapen ears. His intelligence level on the Binet-Simon scale is a little under 10 years. Under institution control he is well-conducted and a useful worker, though lacking in steadiness of application.

Obs. 47. P. M., aged 27, labourer. Murdered a child from motives of lust. There was nothing of note in what little could be ascertained of the patient's family history. He was stated to have been troublesome, deceitful, and vicious as a child. Until about 12 years of age he wet the bed. When he was 11 years old he was sent to a reformatory school for theft, and soon after he had finished his time there he served a sentence of imprisonment for a like offence. He then enlisted in the Army, and a few months later was convicted of sodomy and sent to penal servitude. On release he promptly reverted to thieving, and was again committed to prison. When he came out he did casual work for some months, and then gave himself up to the police, stating that he had killed a woman who had been found dead in her room with her throat cut some months before, and whose death had been attributed to suicide. In the absence of confirmatory evidence, the patient was discharged, and shortly afterwards was certified insane and sent to an asylum. After some years' detention as a moral imbecile, he escaped, went to live with some relatives, and found casual employment. A few weeks later, being alone in the house with a little girl of 11 years of age, the daughter of the landlady, he cut the child's throat and outraged her after death. He then absconded, and evaded arrest for some days, but was eventually found by the police shamming an epileptic fit in the street. The patient is of fairly quick intelligence, grading over 12 years on the Binet-Simon scale. He makes much profession of remorse

for his crime, which he tries to extenuate by denying the violation of the body, and which he attributes to a temporary madness. He is full of excuses for his other offences, which he imputes to his bad upbringing, to the evil influence of his comrades at school and in the Army, and, in fact, to any source except his native perversity. He is very glib with moral and pietistic phrases, and he responds normally and with unction to tests of ethical discrimination. According to his own story, he suffered for some years after leaving the Army from convulsive attacks, frequently occurring in long series. His account of these attacks suggests that, so far as they may have been genuine, they were of hysterical origin. He has never had such seizures while under detention.

Obs. 48. M. S., aged 17, labourer. Murdered an old woman, and mutilated her body after death. Patient's father was intemperate, and had served terms of imprisonment for neglecting his family; a paternal great-uncle, also alcoholic, committed suicide. Patient himself was dull and idle as a boy. On leaving school he worked irregularly as an errand-boy and labourer, but was found inefficient and casual. He associated much with boys and girls younger than himself, with whom he practised various sorts of sexual vice; and he was an assiduous attendant at the local slaughter-houses, where he found sexual gratification from seeing the killing and cutting up of the animals. A short time before the murder, he served a term of imprisonment for cruelty to cats—hanging them up on a rope, pole-axing them, and cutting them up as he had seen the butchers do in the slaughter-house. On the day of the murder he went to the house of his victim, who was a distant relative of his and who had frequently befriended him. As she was preparing tea for him, he struck her from behind with an iron bar

which he had secreted under his coat for the purpose, and, after killing her, dragged her body to the cellar and mutilated her sexual parts. He then took some oranges which he found in the house, and rejoined his comrades in the street, sharing the oranges with them and playing at peg-top till he was arrested. In the asylum he gave a clear and detailed account of the murder, from which it appeared that in the act he had experienced the same kind of gratification that he had obtained in witnessing the slaughter of cattle, in killing the cats, and in his various sexual relations. He showed no trace of remorse or shame in reference to the crime, but seemed rather to find a pleasurable emotion in talking about it and describing its details. He was of slightly subnormal intelligence, failing to reach the level of 12 years on the Binet-Simon scale ; but he showed very fair aptitude for manual work and rapidly acquired some skill at tailoring.

Obs. 49. A. S., female, aged 25, single. Attempted to murder a child (her niece) by throwing her into a river. Patient's immediate relatives were said to be normal, but there was a history of insanity in her father's family. Patient herself was troublesome, deceitful, and a confirmed thief from childhood ; she was irregular in her school attendance and did not get beyond the 3rd Standard ; she wet the bed up to 15 years of age. Menstruation did not begin till she was 18, and was never regular. She was sexually vicious from the time she was a schoolgirl, going with men, and practising masturbation, alone and with other girls. At 16 years of age she was convicted of larceny, and sent to a Home, from which she promptly absconded. Soon afterwards she was sent to prison for loitering with intent to commit felony, and was also supposed by the police to have been concerned in setting fire to a haystack. She was next convicted of burglary,

and sentenced to detention in a Borstal Institution, where she was found to be incorrigible. On discharge she was handed over to the care of a sister, but within a few weeks was caught stealing in a neighbour's house, and was sent to penal servitude for five years. During the term of this sentence she was certified insane. In the asylum she was troublesome, treacherous, and vindictive in her dealings with the other patients; she attempted several times to set fire to her clothing and to furniture, and frequently tried to strangle herself, these tendencies being shown most frequently about the time of her menstrual periods. She showed no definite indications of intellectual disorder, and alleged that the delusional symptoms she had presented in prison were feigned.

Some months after the expiration of her sentence, her sister removed her from the asylum and took her to her home. A few weeks later, she took her niece out for a walk, sat the child on a wall by the river-side, told her to look at the water, and pushed her in. To a man who came along and rescued the child she said, "She climbed on the wall and fell in." Subsequently she admitted to the police what she had done, saying, "I wanted to drown her, and myself as well." In the asylum she showed the same morbid and unstable temper, with occasional brief phases of superficially good conduct and industry. She refused to co-operate in mental tests, but it was evident that her intellectual level was fairly high. With reference to the crime, she would sometimes decline to give any explanation, sometimes attribute it to a "sudden feeling that came over" her, and sometimes say she did it to spite her sister.

Obs. 50. A. W., aged 24, no occupation. Obtained goods from tradesmen in different parts of the country under fraudulent pretences. Nothing was known of the

patient's parentage or of his earlier career, and his statements on these, as on all matters, were utterly unreliable. All that could be definitely ascertained about him was that in his twentieth year he was under treatment for a time in a mental hospital in New York, where he was considered to be a case of paranoid dementia præcox, that he was an inmate of asylums in England and Scotland on three occasions during the succeeding three years, and that the symptoms of insanity which led to his detention in these several institutions appeared on each occasion when he had been arrested or was expecting arrest on charges of fraud. In his latest swindling exploits, which began immediately after his discharge from an asylum in Scotland, his mode of procedure was to assume some high-sounding name, dress himself in the uniform of a Staff officer—it was during the War—put up at a first-class hotel in some large city, run up bills and obtain valuable goods on credit from credulous tradesmen, and then decamp to repeat the same performance in another centre and under another name. At the time of his arrest he was “wanted” by the police of nine cities for exploits of this sort.

His arrest led, as usual, to an immediate appearance of profuse and impressive symptoms of insanity—he talked disjointedly of being followed, threatened, hypnotized, was going to be hanged, to be poisoned, heard menacing voices, saw terrifying spectres, was a lineal descendant of the Duke of Wellington, was authorized by a special Act of Parliament to wear military uniform and to do anything he liked, and so forth. When brought up for trial, he was found insane and unfit to plead, and was sent to the asylum. Soon after his admission, his symptoms of active insanity disappeared, and, though the patient would not confess that they were entirely feigned, he admitted that he could “exaggerate his fancies,” and

was apt to do so under the emotional shock of detection and fear of punishment. His assumption of military rank he explained at first as a symbolic expression of his desire to join the Army and go on active service—a desire which was denied him by his nationality, as he was the son of an exalted Russian noble, massacred, with the rest of his family, by the Bolsheviks. Once he had the uniform on, it was necessary to live up to it, and anyhow, it was criminal folly on the part of tradesmen to let themselves be taken in. As to his choice of rank, he said that at first he posed as a regimental officer, but finding that people were apt to ask awkward questions about friends of theirs in the same regiment, he thought it advisable to go to a tailor's and "join the Staff."

The patient is a man of considerable natural ability and acute intelligence, and would be likely to do well in the world but for his morbid propensity to lying and swindling. This mental twist is, however, so pronounced that even when he seems to make a genuine effort to tell the truth—as when he has undertaken to give a detailed account of any incident while he is timed with a stopwatch—he invariably deviates into fiction within two or three minutes. Apart from his pathological lying, he has not shown any active moral perversity.

These five cases may be taken as illustrating fairly well the general characters of that abnormal constitutional condition which is denoted by the term moral imbecility—namely, the early appearance of vicious and mischievous tendencies, their persistence in spite of the repeated experience of the unpleasant results to the moral imbecile himself which follow their indulgence, and the absence of any sort of moral feeling in relation to them. It will be noted that in two of these patients the moral de-

ficiency was associated with definite intellectual deficiency, and that in the other patients also some amount of intellectual debility must be inferred from the general character of their conduct and their incapacity to profit by experience. This is the mark of their abnormality. Even when, as is frequently the case, the moral imbecile makes quite a good showing with the ordinary mental tests, and displays in his conversation some quickness of wit and some capacity for acute, if superficial, reasoning, his real lack of intelligence is revealed clearly enough by his history. Viewed as a whole, his conduct is patently absurd ; his life is not only evil, it is foolish. And that, in fact, is the characteristic which distinguishes the higher grade moral imbecile from the relatively normal evil-doer ; the moral imbecile, in addition to being a knave, is a fool, because he lacks that essential quality of the normal intelligence, common sense, or, to use the apt and convenient term counselled by Dr. Tredgold, wisdom. It is only when absence or deficiency of moral feeling is combined with at least this amount of intellectual deficiency that we can speak of moral imbecility. Moral insensibility alone, however marked, is not sufficient to constitute this condition.

It is true, no doubt, that a capacity for moral emotion, whatever view we may hold as to its nature and origin, is, in fact, a normal aptitude of man. It is revealed in the feeling of repugnance experienced in regard to conduct which, though safe and profitable, is in conflict with such moral standards as we have adopted instinctively or under the influence of training, this repugnance taking the form of moral indignation when other people's misconduct is in question, of moral suffering or remorse when it refers to our own misconduct. And it is revealed also, of course, in the feeling of admiration called forth by seeing or hearing of acts of self-sacrifice and disinterested courage.

Like other mental attributes, this moral sensibility varies in degree from one individual to another, and in some persons may be conspicuously weak or entirely absent. We may, if we choose, describe such absence of moral feeling as abnormal, but it is clear that we cannot consider it as being so in the same sense that a defect of intelligence is abnormal.

In the present stage of human evolution it is hardly to be assumed that a high development of ethical sensibility, any more than a high development of æsthetic sensibility, is an essential element in our conception of the average man. Whatever be the origin of the moral sense, it is assuredly not a necessary factor in the adaptation of the individual to his environment in the same way and to the same degree as is the intelligence—even the moral enthusiast must admit that in the struggle for existence a lack of ethical feeling may often be an advantage, while a lack of brains is almost always a drawback. Moral insensibility, therefore, even if it be admitted as an abnormal condition, does not suffice to bring the morally insensible person within the definition of a moral imbecile, whatever be the social quality of his conduct, whether he be a law-abiding member of the community or a callous and confirmed criminal. Probably no form of crime, for instance, demands a greater degree of such insensibility than the crime of the treacherous poisoner, but it would obviously be an illegitimate extension of that term beyond its ordinary use to describe as a moral imbecile a man who carried out a crime of this sort with skill and deliberation and for intelligible purposes of personal advantage.

The moral imbecile, then, is not simply an amoral person ; he is an amoral person who presents also some degree of intellectual deficiency ; he is a defective whose congenital debility is predominant, indeed, in the sphere

of the emotions and the will, but affects also, to however slight an extent, the sphere of intelligence. And that presumably is what is meant to be conveyed by the statutory definition of moral imbecility quoted at the beginning of this chapter.

The terms of this definition have been the subject of a good deal of criticism, which, even if some of it may be considered a little captious, would seem at all events to suggest considerable doubt as to whether the attempt to frame a classification of varieties of mental defect by Act of Parliament has any practical utility that is not more than counterbalanced by substantial disadvantages. In particular, it has been objected, and the validity of the objection has been borne out by experience, that the inclusion in the definition of the words "permanent mental defect" tends to cause difficulty and confusion in the administration of the Act. If by these words is meant a defect of intelligence other than can be made out without reference to the imbecile's aberrations of conduct, then there does not seem to be any good reason for taking him out of the category of the feeble-minded, and the definition is superfluous. If, on the other hand, as is more probable, the framers of the statute had in view those cases in which intellectual deficiency can only be inferred from the record of persistently irrational and unprofitable anti-social acts, then it is obvious that their intentions would have been better expressed by a specific statement to that effect, than by the use of terms which appear to imply, and are in practice generally held to imply, the necessity of evidence of mental defect in other directions. From the clinical point of view, it is no doubt convenient to distinguish, under the denomination of moral imbeciles, the particular group of the feeble-minded in whom defect is more obvious in feeling and conduct than in intelligence, but it is difficult to see what purpose

is served by making such a differentiation in a legal enactment.

The criminality of the moral imbecile is distinguished, in typical instances of this condition, by the precocity of its appearance, by the variety of its direction, and by its frequently gratuitous character. In these points it presents a clear contrast to the criminality of the relatively normal habitual delinquent. The ordinary habitual criminal may, and very frequently does, start on his anti-social career in youth, but he does not usually begin in early childhood ; nor does he as a rule practise several sorts of delinquency ; on the contrary, he is more or less of a specialist in his criminal activities ; and these activities are almost always directed to definitely profitable ends. The moral imbecile, on the other hand, is generally an incorrigible thief and liar from the time that his physical and mental development will allow of thieving and lying ; his perversity of disposition is apt to be many-sided, as may be shown in childhood by acts of malicious destructiveness, by precocity in sexual vice, by fiendish cruelty to younger children and to animals, and when he is of criminal age, by a variety of different types of illegality.

This wider range of misconduct, as compared with the exclusively or predominantly acquisitive crime of the habitual delinquent, indicates the profound ethical insensibility of the moral imbecile. The habitual criminal, it is true, may show no evidence of remorse for wrongdoing, but that wrongdoing is for profit rather than for pleasure, and he does not aggravate it by any admixture of superfluous malignancy ; moreover, he will often reveal some trace of ethical sensibility in his efforts to extenuate his conduct by reference to his circumstances or to the attitude of society towards him. But the moral imbecile seems to do evil for its own sake ; his crimes are frequently

unprofitable except in so far as they gratify his perverse instincts ; and, even when he tries, as he often will, to mask his cynicism by a pretence of remorse, his professions of repentance appear to be mainly prompted by a desire to revive the pleasurable emotions which he experienced in the criminal act. This emotional perversity probably accounts in part for the tendency, notably common in moral imbeciles, to accuse themselves of murders which they have not committed. Sometimes these false confessions refer to real crimes, the authors of which have not been detected, so that the self-accusations may be largely prompted by a desire to gain notoriety by association with a *cause célèbre*. But more frequently they are pure inventions in which the moral imbecile indulges his vicious imagination by the recital of mythical atrocities ; thus one patient, who rounded off a varied career in reformatories, prisons and asylums, by an apparently motiveless murder, writes out from time to time confessions of fancied crimes, recounting, for example, in minute detail how he strangled a prostitute in some lonely spot, how he cut out and ate her genitals, and threw her body down a pit.

The foregoing description applies, of course, to the more extreme instances of the condition, in which the absence of moral feeling is more or less general. But since the so-called moral sense "is not a simple activity, but the sum of a set of tendencies,"¹ the character of the emotional deficiency may vary very widely in different cases, according as one or other of the constituent elements is lacking, or is imperfectly developed ; and as, moreover, the form that the impulses eventually assume, and the ideas that become connected with them, are largely influenced by training and circumstance, it follows that the conduct in which moral

¹ Ribot, *Psychology of Emotions*, London, 1897.

imbecility expresses itself may exhibit much apparent diversity.

In all cases, however, there is the common trait of insensibility in respect of the moral quality of the particular form of conduct involved, with a consequent incapacity for experiencing shame or remorse. Individuals of this sort may be taught moral ideas, and many of them are, in fact, very ready with unctuous professions when it is to their interest to conceal their defect; but they are incapable of the feelings and impulses related to these ideas; their morality, as Schüle¹ puts it, is purely theoretical. Unfortunately we still lack satisfactory means of detecting and measuring this emotional insensibility. Methods have, indeed, been suggested for the purpose, such, for instance, as the schemes proposed by Fernald,² who puts before the subject a list of hypothetical acts of vicious character, and invites him to arrange them in the order of their gravity. But these ethical discrimination tests, and the similar tests requiring the theoretical solution of difficult moral situations, are tests of intelligence, not of feeling; and moral imbeciles often respond quite brilliantly to them. For the most part, the diagnosis of the condition must rest on the evidence of persistent and unprofitable perversity which is given by the conduct of the moral imbecile throughout his life, supplemented, it may be, by indications of intellectual debility over and above what may be inferred from the lack of wisdom revealed in his futile career. Such evidence may be sufficient when the point arises in connection with a crime for which the only apparent motive is the gratification of a perverse impulse.

It is a more difficult question when the criminal act can be attributed to an interested motive, as, for instance,

¹ Schüle, *Handbuch der Geisteskrankheiten*, Berlin, 1879.

² Fernald, in *American Journal of Insanity*, April, 1912.

when murder is committed as an incident in an attempt to rob. And the difficulty is the greater because, in such cases, the attitude of the murderer may not be marked by the candour or the cynicism of those moral imbeciles who avow or even exaggerate their misdeeds. On the contrary, it will often be quite similar to the attitude of the ordinary criminal, perhaps differing only in the more strenuous protestations of innocence in face of overwhelming proof of guilt, and in the uncritical combination of more or less plausible lies of detail to form a story which is obviously absurd as a whole. In a case of this sort, the possibility of some slight element of moral imbecility—if, indeed, it need be a matter of practical interest—may be inferred from the evidence of vicious disposition in the murderer's previous history.

It was pointed out above that moral deficiency may be manifest only in respect of certain forms of conduct ; and this limitation of perversity is notably apparent in one large group of defective criminals, namely, the pathological swindlers. The individuals comprised in this group, whose distinctive traits are well illustrated in Observation 49, differ from ordinary sane impostors in the degree in which their swindling propensities dominate their character and colour all their activities ; they seem to be exercising a talent rather than practising a trade ; and, even under the hampering conditions of prison and asylum life, they will continue to lie and cheat, not merely for the sake of trivial advantages, but quite gratuitously, when there is no prospect of gain and a practical certainty of detection with attendant risk of loss of privileges. Their intelligence is, as a rule, of fairly high level, so that, for evidence of their mental debility, reliance must be placed mainly on the precocity and incorrigibility of their perverted conduct, and on their persistent display of the same tendencies in the absence of intelligible motive.



In some instances, also, it is possible to bring out the constitutional character of their untruthfulness by testing their ability to give accurate evidence. Some of these subjects, for example, when tried with the ordinary method in which the details of a picture or a story are to be reproduced from memory, will distort and amplify the original facts with a most remarkable wealth of fantasy, and with every appearance of certitude as to the truth of their testimony. This test, however, is of more value for its positive than for its negative results, for it frequently fails in cases of undoubtedly pathological character.

Apart from their special swindling proclivities, the defectives of this group do not ordinarily show any tendency to gross moral aberrations, so that their potential danger to society is relatively slight as compared with the moral imbeciles whose ethical deficiency is of a more generalized kind.

To complete this summary account of moral imbecility, special reference may be made to two points of interest in connection with it. One point is the frequency with which the condition is associated with simulation or quasi-simulation of active insanity. Thus it is very common in the history of a moral imbecile to find that he has been under treatment in asylums for some form of psychosis, most usually diagnosed at the time as dementia præcox. Ordinarily the onset and duration of the symptoms show a suggestive correspondence with the patient's liability to conviction and punishment, or with some other circumstance that might prompt to malingering; and he will often boast subsequently that his madness was feigned. Even in such cases, however, there may be an element of doubt, for there is reason to think that episodic attacks of mental disorder do occasionally arise on a morbid basis of moral imbecility, and

in some rare instances there may ultimately be a development of permanent enfeeblement of mind with a paranoid colouring. However that may be, the simulation, if it is simulation, is frequently so well carried out as to give the impression that it has, at least, a partial foundation of morbid aptitude.

The second point of note in reference to this type of defect is its affinity with epilepsy, as evidenced by its frequent development in the offspring of epileptic stock, or in sequence to head injuries in childhood, and by the occasional supervention of epileptic fits later in the subject's life.

In some cases of juvenile crime it may be difficult to decide whether the condition is one of permanent defect or merely of moral retardation. The following observation will illustrate the point :—

Obs. 51. L. K., aged 14, schoolboy. Murdered a child of 3 by tying a rope round his neck and shutting him up in a chest. There was nothing of note in the family history, and the patient himself was said to have been normal until he was 6 years of age, when he began to suffer from "fits" attributed to a fall on his head. Owing to these fits his attendance at school was very irregular, and he was allowed to loaf about a good deal and to indulge in petty mischief, which was excused on account of his supposed infirmity. He had not, however, shown any dangerous tendencies prior to killing the child. The crime was not discovered until about a fortnight after the victim had disappeared, when the body was accidentally found in the chest.

In the interim the patient's fits had become much more frequent and severe, and he had in consequence been sent to the Union Infirmary. After the discovery of the body the patient was questioned by the police as to when he had last seen the child, and in reply said, "I have

not done anything to George." When told how the body had been found, he professed entire ignorance of the affair. After a night in the police station, however, he said to the inspector, "I have had a dream and some of it has come back to me. I put him in a box, covered him with clothes, and shut the lid up. I put an old bed on the box. I did not know I had done it till last night, when I had the dream." Some days later he said, "I have had another dream. I put him in the box alive. I tied him up when he was alive." The defence of epileptic automatism was set up, and the patient was found Guilty but Insane.

On admission to the asylum he repeated the same story that he had told the police, with additional details, also purporting to have been learned in dreams and fitting in with what he had heard about the theory of automatism at his trial. According to this more detailed account, he had brought the child home with him, and after showing him his toys had carried him up to the garret, taking with him a rope which he had recently bought, and had tied the rope round his neck and put him into the box. He then laid down on the bed in a room next the garret, and went to sleep, and on waking up had no recollection of how he came to be there or of anything that had happened. This blankness of memory, he asserted, continued till he had the dream the night after his arrest. "I knew nothing about it till it came back to me in a dream; I was not in my right senses; it happened in a fit." The alleged recovery of memory in the dream did not extend to a recollection of the motive of the act.

 Patient is an alert and intelligent youth; his responses to the Binet-Simon tests rank him well up to the normal, and in certain tests, such, e.g., as the interpretation of pictures, he shows a keen appreciation of the emotional

situation. He has made rapid progress in tailoring work, and is quick at games. On the other hand, he is sexually vicious, foul-mouthed, sly and deceitful, and shows a morbid preoccupation with crimes of blood, tearing out from the papers and secreting accounts of cases in any way resembling his own. The account which he gives of the alleged fits does not show any definitely epileptic characters, and he has had no recurrence of the attacks in the asylum, either spontaneously or under the test of chloride diet after abrupt discontinuance of bromide. While insisting on the genuineness of his seizures, he admits, what is in fact the case, that they began at a time when he was much in company with a boy subject to true epilepsy.

It is difficult to form any decided opinion as to the origin of the murder in this case. The facts that the patient was entering on the stage of puberty, and that he was addicted to masturbation, point to the possibility of a sadist factor ; while his vivid recollection of tying-up scenes on the cinema, of which he was a very assiduous patron, might perhaps suggest that the affair began in imitative play, and then turned to tragedy either through the development of morbid impulse or from sudden scare at the prospect of punishment. It also remains doubtful whether the " fits " were simply feigned, or were genuinely hysterical, their accentuation between the time of the murder and the discovery of the crime being due to emotional conflict and repression ; they were certainly not epileptic. The question whether the boy's vicious habits and his moral insensibility in regard to his conduct indicate a permanent deficiency, or are to be set down to the account of immature development, can only be settled by time. In cases of this sort, which are not very rare, the patients sometimes become normal as they grow up, and sometimes remain morally imbecile, without its

being possible, in most instances, to predict which of these results will ensue.

To complete this account of moral imbecility, it is necessary to refer to a group of cases in which the underlying anomaly of temperament is revealed chiefly in weakness of inhibitory control, while the element of emotional insensibility is relatively slight. It has been occasionally questioned whether the individuals of this group should be included in the class of moral imbeciles ; but, inasmuch as their constitutional defect appears to be of closely similar origin and nature, and impels them very generally to a similar career of persistently anti-social conduct, there seems to be no sufficient reason for separating them from the larger category, merely on the score of their lesser degree of affective obtuseness. The following observation illustrates very fairly the characteristics of these morbidly impulsive criminals.

Obs. 52. J. M., aged 31. Murdered a N.C.O. while in military training. The patient came of a notably unstable and neurotic stock, and from his boyhood spent most of his time in reformatory and penal institutions, where he was constantly in trouble through his uncontrollable temper and his intolerance of discipline. His criminal activities were in part professional, and in part the result of his morbid impulsiveness. Enlisting immediately on his release after a term of imprisonment, he conducted himself satisfactorily up to the time of the murder, some two months after he joined the Army. The crime was committed on the shooting range, where the patient with other recruits was receiving musketry instruction. Being reproved for his poor shooting, he complained to the officer in command that one of the sergeant-instructors had called him a d—— fool ; the sergeant denied this, and was supported in his denial by others present ; the patient then said that he felt too nervous to fire, but

was ordered to go on. He went to his place, loaded his rifle, and, turning round, aimed straight at another sergeant-instructor, with whom he had had no previous relations, and shot him dead, calling out that he was going to shoot another man too. When overpowered and taken to the guard-room he appeared quite cool and collected. Later, when questioned as to his motive, he said, "I can't tell you ; I had a curious feeling come over me, over which I had no control." While in gaol awaiting trial, he was occasionally violent and destructive, as he had frequently been in his previous sojourns in prison.

These phases of excitement occur also at irregular intervals in the asylum, usually in connection with some trivial annoyance, but sometimes spontaneously and in a way somewhat suggestive of an epileptic temperament. He has a certain degree of insight into his condition, and will frequently ask to be secluded when he feels that he is losing control of himself. Apart from his occasional outbursts and his constant instability of temper he is well-conducted, sociable, and a good worker. He shows some appreciation of his crime, and tries to palliate it by saying that it was an accident, or that he had been drinking.

In the foregoing case the occurrence of the impulsive outbursts without any, or with absurdly trivial provocation, shows with sufficient clearness the patient's abnormality of organization. When the constitutional weakness of inhibitory power exists only in a minor degree, and is mainly to be inferred from the evidence of a pronounced insane or epileptic taint in the family history, it must, of course, be very largely a matter of pure conjecture whether the impulse leading to the criminal act was really uncontrollable or merely uncontrolled. The circumstances leading up to the crime, the presence or absence of an interested motive, and the behaviour

of the criminal after the act, will sometimes provide material for a more or less speculative judgment on the point. The question may frequently be of some practical importance, for, in these less clearly defined cases, as, indeed, in many instances of undoubted moral imbecility, the constitutional anomaly does not appear to be of such kind and degree as could be safely admitted to exempt the subject of it from liability to legal penalties.

CHAPTER XIV

MENTAL DISEASE AND CRIMINAL RESPONSIBILITY

We have now completed our survey of the facts of morbid crime, and our next task is to consider, in the light of these facts, the practical problem of the relation of mental disorder to criminal responsibility. Responsibility in this connection means liability to the punishments which the law attaches to those acts or omissions which it qualifies as criminal offences, so that the special subject of our present inquiry may be said to be the question whether and in what manner and degree this liability to punishment should be modified or abolished be reference to any morbid mental condition which may exist in the offender. For the profitable discussion of this matter it is obviously necessary to begin by getting a clear idea of the nature and object of legal punishment in general ; before we consider modifications of punishment, we must understand what it is that we may propose to modify.

As has been already pointed out, the very definition of crime involves the conception of punishment. It is of the essence of a criminal act that it should render the offender liable to suffer penalties prescribed by the law. Crimes, and punishments for crimes, are phenomena of all communities from the most primitive to the most highly civilized ; the social group, however rudimentary be its organization, implies some measure of subordina-

tion of individual to community interests, some acceptance of rule and custom, and consequently some mode of collective reaction against those members of the group who violate its embryonic laws. That reaction is punishment in the sense in which we here use the term, that is to say, in Westermarck's words, it is "suffering inflicted upon an offender in a definite way by, or in the name of, the society of which he is a permanent or temporary member."¹ Thus, at bottom, and in its historical evolution, punishment is simply the reaction of the community against an act which threatens, or is supposed to threaten, its well-being—it is, in fact, and that is its ultimate and sufficient justification, a procedure of self-defence.

There has been much discussion as to the emotional attitude which accompanies, or which ought to accompany, this social reaction; and numerous theories have been put forward regarding the nature and aim of punishment, whether it should be retributive or deterrent or reformatory in its purpose.² These theories are rationalizations of the fundamental instinctive tendency which impels the community to protect itself against its anti-social elements; and, since the rationalizations of the group are produced in much the same way and have much the same significance as the rationalizations of the individual, we may take it that the various doctrines in question represent little more than the prevailing spirit of the epoch in which they are propounded or the personal sentiments of the speculative thinkers who propound them. It is not necessary, therefore, to enter here on any detailed discussion of their relative merits.

¹ Westermarck, *Origin and Development of the Moral Ideas*, vol. 1, p. 169, London, 1912.

² McConnell, *Criminal Responsibility and Social Constraint*, London, 1912.

It is sufficient for us to note that the social feeling which is nowadays associated with the institution of legal punishment is, in fact, appropriate in some measure to all the aims which we have specified. The retributive sentiment is evidenced clearly enough by the popular demand for the infliction of the death penalty rather than perpetual imprisonment in particular instances of atrocious crime, even though the crime may be of such exceptional character that deterrence by example can hardly be a motive for punishment; the deterrent element, again, is shown by the agitation for more stringent penalties for any category of serious offences which may be tending to increase in frequency; and the reformatory aim is, of course, manifest in the increasing insistence on the introduction of educational and moral training into the penal system.

It is of more interest to inquire what punishment does, in fact, achieve, and how far these several aims are realized in its actual results. First, as to its retributive aim: in so far as that aim includes the exacting of compensation for the material damage done to the community by the criminal act, it is not achieved in an appreciable measure by any of the ordinary legal penalties, partly, no doubt, by reason of the very unintelligent character of penal "systems." On the other hand, it is generally admitted that the retributive aim is realized to the extent that the infliction of punishment satisfies the vindictive feeling of the community. It is, however, by no means agreed that this is in itself a desirable result, and the present trend of opinion—or at all events of the opinion which is most vocal—would seem, indeed, to regard any such emotion as a survival of primitive savagery. As against this view, however, it has to be borne in mind that the feeling of moral indignation aroused by crime is part of the normal social reaction,



and that the fear of arousing such a feeling in the group is perhaps even more potent as a deterrent from crime than is the anticipation of material suffering.

It is not without significance in this connection that the rejection of the retributive doctrine of punishment appears to be most strongly advocated in communities where the law does not correspond to the deeper group feelings, but has been perverted to the service of temporary fanaticisms, so that much of the conduct which it brands as criminal is ethically indifferent, or at all events involves no such injury to society as should bring it within the sphere of legal control. And it may be added that it is in such communities also that there is most tendency to explosions of the vindictive emotion in the form of mob violence and the lynching of real or suspected criminals. In dealing with so deeply rooted an instinct of human nature, it would perhaps be more advisable to regulate it than to ignore its existence, and this all the more because, as we have seen, it probably contributes in a considerable measure to the main effect of punishment, namely, its deterrent effect. As to the importance of this latter mode of action, there is little need for argument: apart from the positive evidence of experience, the universal belief in the deterrent value of punishment is in itself in some sort a proof of its efficacy. In the determination of conduct a belief has the force of a reality, and when the average man feels, as he does feel, that legal punishment, and the disgrace that attaches to it, act as motives that deter him from crime, there is no reason to question their potency. And in point of fact it is hardly questioned except by those who maintain the extreme biological view of an innate specific tendency as the basis of crime, a doctrine which we have already examined and rejected in an earlier chapter.

Such other criticisms as have been directed against the deterrent value of punishment have been concerned for the most part with secondary points, as, for instance, the efficacy of particular penalties, the relation of the severity of punishment to its deterrent influence, the failure of punishment to prevent recidivism, and so forth. These criticisms, so far as they are valid, apply only to the corrective aspect of deterrence ; they do not touch its much more important preventive aspect : it may well be that actual experience of punishment, whether mild or severe, has little influence on the criminal, but this is not in the least inconsistent with the fact that the anticipation of such punishment, and of the consequences attendant on it, has a potent effect in restraining the potential law-breaker. And it is nowhere more true than in regard to crime that prevention is incomparably more important than cure. Of the strictly reformatory element, as distinguished from the retributive and deterrent elements of punishment, we need say little ; its development is still too limited and its principles are too uncertain to provide any data for a judgment of its value, and in any case it has comparatively slight bearing on the question with which we are specially concerned, viz., the effect of mental disorder on penal liability.

Before recurring to that question and considering how far the retributive and deterrent aims of punishment are subject to modification in the case of offenders of abnormal mentality, it is necessary to indicate briefly the actual methods by which it is sought to give effect to these aims in the existing penal systems. So far as concerns serious delinquency, there are practically only two methods of legal punishment now in use—the death penalty and imprisonment. Corporal punishment in the form of flogging is so nearly obsolete except under abnormal social conditions that it may be left out of account.

And fines, as an alternative to imprisonment, are, of course, very rarely imposed in the case of grave offences.

Imprisonment, which was originally employed merely as a means of holding the accused person at the disposal of justice until his trial, and, in the event of his conviction, until he had received whatever bodily punishment was allotted to him, has in the process of time become itself the chief punitive method applied by the law. It has been, and still is, no doubt, associated with various conditions which are supposed to reinforce its deterrent or its educative influence, but these conditions, whether designed to make it more irksome or more moralizing, are quite negligible in comparison with its essential element—the privation of liberty. That at all events is the only element which really impresses the prisoner; what matters to him is the fact of detention, and not his sanitary or hygienic surroundings or his opportunities for literary pursuits or spiritual exercises. If the attitude of the criminal on this matter were better appreciated, it might perhaps go some way to relieve the anxiety of the reformers who fear that prisons may not be comfortable enough, and the still more futile anxiety of the disciplinarians who fear that they may be made too comfortable; and it should certainly lead to a more modest estimate of the value of those elaborate and costly penal “systems” whose description is so strikingly suggestive of an extract from the proceedings of the Academy of Lagado. Unfortunately, the Royal Commissions and other imposing bodies who make solemn inquiries into these matters, do not usually include in their membership any experienced and representative gaol-birds; if they did their Reports would probably be different—and possibly more valuable.

As we are concerned only incidentally with penalogical questions, any discussion of the possibilities of improved

and more varied modes of social reaction against crime would be beyond the scope of our inquiry; we have merely to recognize the fact that at the present time this reaction takes two forms—capital punishment in the case of murder and treason, and imprisonment in the case of all other serious offences. What we have to consider, therefore, is whether and in what way liability to undergo these two penalties is, or ought to be, affected by a state of mental disorder or abnormality in the criminal. And, since it is only in regard to capital punishment that there is a radical and irrevocable difference in the mode in which society reacts against the sane and against the insane offender, the matter is of practical importance mainly in cases of murder; the plea of insanity in extenuation of guilt is, in fact, rarely raised except in such cases; and it may be added that it is chiefly as potential homicides that the insane are a menace to public security. The same principles are, of course, involved in all forms of crime related to morbid mental conditions in the criminal, so that whatever conclusions may be reached with regard to criminal responsibility in homicidal cases may be considered as having theoretically a general application.

In primitive communities the only point considered in the punishment of crime was the objective character of the criminal act; no account was taken of the element of intention, and full responsibility was accordingly imputed to all sorts of agents, even to lifeless things and to the lower animals. With the progress of civilization a new tendency developed in the regulation of legal punishment, and it came to be recognized that criminal responsibility might be affected by the subjective state of the offender, by the extent to which he had willed the forbidden act. This conception of intent as an essential element in criminal conduct is indicated, though

not very definitely, in the Mosaic law and in ancient Roman law ; it is clearly stated in the Justinian jurisprudence, and is applied there, *inter alia*, to the specific case of offences committed by insane persons. If the offender was in a state of *furor*—a term originally denoting maniacal excitement, but eventually used in reference to insanity in general—he was immune from punishment. In the matter of criminal responsibility, the *furiosus* was in the same position as the child—“*Infans vel furiosus, si hominem occiderint, lege Cornelia non teneantur, cum alterum innocentia consilii, alterum fati infelicitas, excusat.*” And again, with specific reference to parricide—“*Sane si per furorem aliquis parentem occiderit, impunitus erit . . . nam sufficere furore ipso eum punire.*” (Pandects, Liber XLVIII, caput 8). Blame for the criminal acts of an insane person was rather to be imputed to those who had failed to exercise proper supervision over him—“*nam custodes furiosis non ad hoc solum adhibentur, ne quid perniciosius ipsi in se moliantur, sed ne aliis quoque exitio sint.*” (Pandects, Liber I, caput 18).

The spirit shown in this enlightened attitude did not, however, develop, or even persist, in the legal institutions of the states which arose out of the ruins of the Roman Empire ; and in most of the countries of medieval Europe, mental disorder, except in very pronounced form, did not save the offender from the full rigour of the law. Thus in Germany in the eleventh and twelfth centuries, madness, whatever its degree, was not admitted as a ground for mitigation of punishment in cases of homicide, unless the guilty person had demonstrated his insanity by inflicting grievous injuries on himself at the time of the murder.¹ Even when, in the later Middle Ages and at the time of the Renaissance, there was a revival of

¹ Osterlen, in *Schmidt's Jahrbuch*, 1877.

the humaner principles of the Justinian doctrine, and when, as in Italy in the sixteenth century, jurists and physicians were elaborating a system of forensic psychiatry which has hardly been bettered by modern science, the harsher attitude of the primitive period was still maintained amongst the peoples of northern Europe. In Germany, according to Westermarck, "recognized idiots and madmen were not seldom punished with great severity and even with death, in the seventeenth and eighteenth centuries."¹

The strength of these primitive tendencies, and their persisting influence on legal institutions, are peculiarly well-illustrated by the history of the law of England with regard to the criminal responsibility of the insane. As the earlier phases of legal doctrine concerning this question have an important bearing on its present position, and account to some extent for the difficulties which have impeded the path of reform, it is desirable for the purposes of our inquiry to examine them in some detail.

The first clear and authoritative exposition of the accepted practice in this matter was that given by Sir Matthew Hale in his *Pleas for the Crown*, written towards the end of the seventeenth century. Hale, after differentiating idiocy, or *dementia naturalis*, from insanity proper, or *dementia adventitia*, goes on to say, in reference to the latter condition—"There is a partial insanity and a total insanity. The former is either in respect to things—*quoad hoc vel illud insanire*. Some persons that have a competent use of reason in respect of some subjects are yet under a particular dementia in respect of some particular discourses, subjects or applications ;—or else it is partial in respect of degrees ; and this is the condition of very many, especially melancholy persons, who for the most part discover their defect in excessive fears

¹ Westermarck, *op. cit.*, vol. 1, p. 273.

and griefs, and yet are not wholly destitute of the use of reason ; and this partial insanity seems not to excuse them in the committing of any offence for its matter capital ; for doubtless most persons that are felons of themselves and others are under a degree of partial insanity when they commit these offences."

The principle which Hale here assumes as the basis of his doctrine—the principle, that is to say, that, in relation to criminal responsibility, disorder of intellect, being "wholly destitute of the use of reason," is the sole criterion of insanity—has been rigidly maintained in the theory of English law down to the present day ; and, though changes have been made from time to time in its judicial interpretation, these changes have been limited to defining the kind and degree of intellectual disorder which may exempt a lunatic from the ordinary penalties of the law. The chapter of legal history which deals with this subject is, in fact, merely a record of successive attempts to arrive at a forensic test of intellectual capacity.

The test which Hale himself suggested for this purpose has a curious appearance of anticipating modern methods of measuring intelligence : he proposed to impute responsibility to an accused person who, though "labouring under melancholy distempers," had nevertheless "ordinarily as great understanding as ordinarily a child of fourteen years hath." It is hardly probable that Hale was to such an extent a precursor of Binet and Simon that he had any very clear notion of the average mentality of a child of 14 years : otherwise his choice of this criterion would seem to imply that, considering the times he lived in, he was surprisingly indulgent in his attitude to the insane offender. It is more likely that he was content to form his ideas on the matter rather from the assumptions of legal theory than from the results of actual observation. However that may be, the standard

of insanity in criminal cases which was practically applied in the English courts from Hale's time down to the end of the eighteenth century, and which claimed the support of Hale's authority, was of a very much more rigorous character. It finds typical expression in the well-known charge of Lord Justice Tracey, who, in the case of the lunatic Arnold in 1723, instructed the jury that a madman is not to be exempted from punishment unless he is "totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute or a wild beast."

In the early years of the nineteenth century this extreme position was somewhat modified, and in certain judicial pronouncements the test of responsibility was now asserted to be the capacity of the accused person to distinguish between right and wrong, either in the abstract, or, according to some judges, with reference to the particular criminal act in question. Legal practice continued in this variable and uncertain way up to 1843, when an event occurred which brought the matter into great prominence, and led to an outburst of angry feeling on the part of that emotional section of the community who appear to live under constant apprehension of the designs of the medical profession, fluctuating between a panic fear that doctors want to lock up sane people in asylums and an equally silly suspicion that they are always ready to protect murderers, to the prejudice of public security, by giving them, without adequate grounds, the excuse and privilege of madness.

This event was the acquittal, on the plea of insanity, of the lunatic McNaughten who had murdered Mr. Drummond, Sir R. Peel's private secretary. The circumstances of the case were not in themselves remarkable, or at all events would not seem so to our present-day opinions. McNaughten had suffered for a long time from

definite delusions of persecution, and within two years of the murder had made repeated applications to public authorities for protection against his imaginary enemies. In fact, the only striking feature in the affair was that a man expressing such ideas should have been allowed to be at large. On the convincing evidence of established insanity which was produced at the trial, it was hardly possible for the jury to do otherwise than to find McNaughten irresponsible. Nevertheless the verdict raised an outcry, one result of which was that the House of Lords took the unusual, though not entirely unprecedented, course of propounding to the bench of judges a series of questions as to the law "respecting alleged crimes committed by persons afflicted with insane delusions in respect of one or more particular subjects or persons." The replies of the judges, commonly known as the McNaughten Rules, have since then constituted the authoritative doctrine of the law of England with reference to the criminal responsibility of the insane. On that account, and because of the acute controversies to which these so-called rules have given rise, it is necessary to discuss them somewhat fully.

The questions formulated by the House of Lords were five in number :

(1) What is the law respecting alleged crimes committed by persons afflicted by insane delusions in respect of one or more particular subjects or persons : as, for instance, where, at the time of the commission of the alleged crime, the accused knew he was acting contrary to the law, but did the act complained of with a view, under the influence of insane delusion, of redressing or revenging some supposed grievance or injury or of producing some supposed public benefit ?

(2) What are the proper questions to be submitted to the jury when a person afflicted with insane delusion

respecting one or more particular subjects or persons is charged with the commission of a crime (murder, for instance), and insanity is set up as a defence ?

(3) In what terms ought the question to be left to the jury as to the prisoner's state of mind at the time when the act was committed ?

(4) If a person under an insane delusion as to existing facts commits an offence in consequence thereof, is he thereby excused ?

(5) Can a medical man, conversant with the disease of insanity, who never saw the prisoner previously to his trial, but who was present during the whole trial and the examination of all the witnesses, be asked his opinion as to the state of the prisoner's mind at the time of the commission of the alleged crime, or his opinion whether the prisoner was conscious, at the time of doing the act, that he was acting contrary to law, or whether he was labouring under any and what delusions ?

To these questions the judges replied as follows :

(1) Assuming that your lordships' inquiries are confined to those persons who labour under such partial delusions only, and are not in other respects insane, we are of opinion that, notwithstanding the party accused did the act complained of with a view, under the influence of insane delusion, of redressing or revenging some supposed grievance or injury, or of producing some public benefit, he is nevertheless punishable, according to the nature of the crime committed, if he knew, at the time of committing such crime, that he was acting contrary to law, by which expression we understand your lordships to mean the law of the land.

(2) and (3) As these two questions appear to us to be more conveniently answered together, we have to submit our opinion to be that the jurors ought to be told, in all cases, that every man is presumed to be sane, and

to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction ; and that to establish a defence on the ground of insanity, it must be clearly proved that at the time of the committing of the act the accused party was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing ; or, if he did know it, that he did not know he was doing what was wrong. The mode of putting the latter part of the question to the jury, on these occasions, has generally been whether the accused, at the time of doing the act, knew the difference between right and wrong ; which mode, though rarely, if ever, leading to any mistake with the jury, is not, we conceive, so accurate when put generally and in the abstract, as when put with reference to the party's knowledge of right and wrong in respect to the very act with which he is charged. If the question were to be put as to the knowledge of the accused solely and exclusively with reference to the law of the land, it might tend to confound the jury by inducing them to believe that an actual knowledge of the law of the land was essential in order to lead to a conviction ; whereas the law is administered upon the principle that every one must be taken conclusively to know it, without proof that he does know it. If the accused was conscious that the act was one which he ought not to do, and if that act was at the same time contrary to the law of the land, he is punishable ; and the usual course, therefore, has been to leave the question to the jury whether the accused had a sufficient degree of reason to know he was doing an act that was wrong ; and this course, we think, is correct, accompanied with such observations and explanations as the circumstances of each particular case may require.

(4) The answer must, of course, depend on the nature

of the delusion ; but, making the same assumption as we did before—namely, that he labours under such partial delusion only, and is not in other respects insane—we think he must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real. For example, if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment. If his delusion was that the deceased had inflicted a serious injury to his character and fortune, and he killed him in revenge for such supposed injury, he would be liable to punishment.

(5) We think the medical man, under the circumstances supposed, cannot in strictness be asked his opinion in the terms stated, because each of those questions involves the determination of the truth of the facts 'deposed to, which it is for the jury to decide, and the questions are not mere questions upon a matter of science only, in which case such evidence is admissible. But where facts are admitted or not disputed, and the question becomes substantially one of science only, it may be convenient to allow the question to be put in that general form, though the same cannot be insisted on as a matter of right.

Though these questions and the replies to them refer explicitly to criminal acts committed by persons suffering from insane delusions—that being the accepted position in the McNaughten case—the rules have usually been regarded, and have constantly been interpreted in legal practice, as having a general application to the plea of insanity, whatever the form and degree of mental disease alleged to exist. Thus the recognized test of responsibility has been founded on the terms of the judges' answer to the second and third questions, which lays down that

for the establishment of a defence on the ground of insanity, it must be proved that the accused party did not know the nature and quality of the act or that it was wrong; and it is in this form that the issue is put even in cases where there is no question of delusion.

It will be observed, therefore, that in this test, as in the whole spirit of the judges' answers—and it is in illustration of that spirit that they have been here quoted *in extenso*—these legal authorities have adhered strictly to the traditional doctrine of English law in making disorder of intellect the sole criterion of responsibility in mental disease. The insanity that is a bar to criminal responsibility must be a defect of *reason* which interferes with the offender's capacity for *knowing* the nature and quality of his act. Intellectual aberration is, in fact, conceived to be the cause, and, so far as legal responsibility is concerned, the sole cause of insane conduct. And, as a corollary to this theory, the criminal acts of an insane person are admitted to be the outcome of his disease only if they stand in logical connection with his intellectual derangement. This is clearly laid down in the judges' reply to the fourth question concerning the relation of the content of delusion to the responsibility of the deluded person.

Reserving for a later stage the discussion of the doctrinal principles of this forensic test of insanity, we shall complete our survey of the question in its historical aspect by inquiring how the test has worked in practice, and how far the proof which experience has given of its value has tended to modify legal opinion. To put the matter shortly, it may be said that the effect of the test has been to leave the issue almost entirely in the hands of the presiding judge, who, at his discretion, may instruct the jury in the strict terms of the McNaughten rules, which would make most insane criminals fully

responsible, or may vary the interpretation of the rules, or wholly ignore them, so as to ensure the exemption of the offender from punishment. There is unlimited scope for this latter mode of procedure, since it is impossible to challenge the direction of the judge or the verdict of the jury when a murderer alleged to be insane is declared irresponsible, even though the evasion or distortion of the legal formula in his favour is effected in an obviously artificial way.

The possibilities of this method of circumventing the difficulties of the McNaughten test have been ingeniously expounded by Sir J. F. Stephen in his *History of the Criminal Law of England*. Answering the question, "What is meant by labouring under such a defect of reason as not to know the nature and quality of the act and that it was wrong?" this author replies, "I think that anyone would fall within the description in question who was deprived, by disease affecting the mind, of the power of passing a rational judgment on the moral character of the act he meant to do. Suppose, for instance, that by reason of disease of the brain a man's mind is filled with delusions which, if true, would not justify or excuse his proposed act, but which in themselves are so wild and astonishing as to make it impossible for him to reason about them calmly, or to reason calmly on matters connected with them. Suppose, too, that the succession of insane thoughts of one kind or another is so rapid as to confuse him, and finally suppose that his will is weakened by his disease, that he is unequal to the effort of calm, sustained thought upon any subject, can he be said to know, or have a capacity of knowing, that the act which he proposes to do is wrong? I should say he could not." And in charging the jury in a case raising this particular issue, Sir J. Stephen laid down the same principle in simpler terms. "If," he instructed the

jury, "you will exercise your judgment in the matter, you will probably see that knowing the act is wrong means nothing more or less than the power of thinking about it the same as a sane man would think about it."

In the great majority of murder trials where the offender has been certainly insane, the test has been interpreted more or less after this elastic fashion, and so any risk of a serious miscarriage of justice has been averted. While in the relatively rare instances in which judges have adopted a less enlightened attitude and have succeeded in imposing their views on the jury, the danger of any such untoward result is effectually guarded against by the opportunities for revision of the death sentence provided by the special powers conferred on the Secretary of State under section 2 (4) of the Criminal Lunatics Act, 1884 (vide Appendix), and since 1907 by the right of appeal to the Court of Criminal Appeal. In practice, therefore, the legal doctrine of criminal responsibility has been innocuous: it has not produced its logical consequences, because it has never been fully applied.

This fact does not, however, furnish any answer to the criticism of the M'Naughten test as being unsound in principle, and faulty and confusing in form; it is rather to be regarded as an admission and a proof of the validity of these criticisms. The inadequacy of the test has, indeed, been very widely recognized by lawyers as well as by medical men, and, on the several occasions when the question has been the subject of special inquiry—as by Royal Commissions in 1865 and 1879, and by a Select Parliamentary Committee in 1874—the majority of the witnesses examined have been in agreement as to the unsatisfactory state of the law on this point. The proposals for its amendment have been chiefly in the direction of extending the test by the recognition of irresistible impulse as a further condition excluding responsibility.

This extension has been admitted by the court in several cases, e.g. in the cases of *R. v. Jordan* (1870), *R. v. Gill* (1883), and *R. v. Hay* (1911); and it was also allowed by Mr. Justice McCardie in the recent case of *R. v. True*, where the issues left to the jury, in addition to the customary McNaughten questions as to knowledge of the nature and quality of the act and knowledge of its wrongness, included the question, "Even if the prisoner knew the physical nature of the act, and that it was morally wrong and punishable by the law, yet, was he through mental disease deprived of the power of controlling his actions at the time?" In *R. v. True* the jury rejected the defence of insanity, and the case was taken to the Court of Criminal Appeal, where the judges, while avoiding a definite pronouncement on the admissibility of the doctrine of irresistible impulse, as not arising in the particular instance before them, pointedly abstained from approving that doctrine, and explicitly reaffirmed the authority of the McNaughten rules.

The issue of this case, in which the convict was certified insane after a statutory inquiry under section 2 (4) of the Criminal Lunatics Act, 1884, gave rise to some popular emotion of the same sort that had been aroused by the acquittal of McNaughten; and, to complete the parallelism between these two *causes célèbres*, the then Lord Chancellor, Lord Birkenhead, appointed a Committee of distinguished lawyers, with Lord Justice Atkin as Chairman, "to consider what changes, if any, are desirable in the existing law, practice, and procedure relating to criminal trials in which the plea of insanity as a defence is raised, and whether any and, if so, what changes should be made in the existing law and practice in respect of cases falling within the provisions of section 2 (4) of the Criminal Lunatics Act, 1884." The report of the Committee, which was issued in

November, 1923 (Cmd. 2005), made the following recommendations as regards the legal test of responsibility:

"1.—It should be recognized that a person charged criminally with an offence is irresponsible for his act when the act is committed under an impulse which the prisoner was by mental disease in substance deprived of any power to resist.

"2.—Save as above, the rules in McNaughten's case should be maintained."

This authoritative expression of legal opinion is thus, apart from the occasional pronouncements of individual judges, the first definite departure from the traditional doctrine of English law—the doctrine that disorder of intellect is the sole criterion of mental disease in relation to criminal responsibility. The admission of uncontrollable impulse arising from insanity as a ground for exemption from punishment for a criminal act, even when there is no proof of failure of insight into the nature and quality of the act, will obviously involve so revolutionary a change in legal theory that it can hardly fail to arouse considerable opposition; and it may, accordingly, be some time before the new principle becomes firmly established, either by legislation or by regular judicial practice. The fact, however, that it has been put forward, not by amateur and pragmatical reformers, but by an exceptionally representative body of legal and administrative experts, of no less authority than the original begetters of the McNaughten test, may be taken to ensure its ultimate adoption; and it can, therefore, be regarded as coming within the scope of this brief historical sketch of the attitude of the English law concerning the effect of insanity on criminal responsibility.

The consideration of this question in its theoretical aspect, and the examination of the general principles underlying the legal doctrine of responsibility, will be the subject of another chapter.

CHAPTER XV

MORBID CRIME AND SOCIAL SECURITY

Having discussed in the last chapter the evolution of the legal doctrine regarding the criminal responsibility of the insane, and having examined in some detail the accepted standards of the English law for the determination of the issue of responsibility in forensic practice, we have now to examine the question from the psychiatric point of view, and to inquire how far the conceptions of legal theory accord with the ascertained facts of clinical experience. As we touch here upon matters which have long been the theme of heated and, at times, acrimonious controversy between the legal and the medical profession, it is desirable to define at the outset as clearly as possible the scope and object of the critical review on which we propose to enter, and to give reasons why such a review can come at all within the legitimate sphere of psychiatry.

Criminal responsibility is a purely legal question. The law, which is the formal expression of the will of the community, is the sole authority in the definition of responsibility; it can impute full responsibility to all offenders, whether they be sane or insane, and, if it does choose to recognize insanity as a condition excluding or diminishing responsibility, it may fix whatever limits it thinks fit to the mode and extent of such recognition. If it establishes tests for this purpose, they are merely tests of responsibility; and it is idle, therefore, for medical

critics to attack them on the ground that they purport to be tests of insanity, and that, in setting them up, legal authority is going outside its province and is seeking to define a morbid condition of which it has no real knowledge. Criticism on these lines is irrelevant and unjust. The fundamental aim of legal punishment is public security, and it is obviously right and necessary that the law should be extremely cautious in admitting limitations of responsibility, lest by so doing it should imperil this essential object. That is why, in regard to the responsibility of insane persons, the law has endeavoured—whether wisely or not we shall consider later on—to devise means of differentiating between the morbid offender who may be excused from ordinary punishment without detriment to the general safety, and the morbid offender whose immunity from penal sanctions would weaken the protective forces of society. In principle, therefore, there is no objection to be taken to the attitude of the law in this matter, if it be granted that legal punishment has any value at all.

But that is not to say that the actual standards of responsibility laid down by the law are sacrosanct oracles in regard to which psychiatric criticism is impertinent and presumptuous; they are, on the contrary, quite proper subjects for such criticism, but from a different point of view. What psychiatry may legitimately ask, and is, indeed, bound to ask, concerning the legal criteria of responsibility, is how far they are adapted to secure the ends which the law has in view in establishing them; and on that question the conclusions of medical science are not merely relevant, they are essential to a sound judgment.

Why, in fact, do civilized communities abstain from punishing madmen for their crimes? So far as this leniency has a rational basis, it is due in part to a recogni-

tion of the fact that mental disease abolishes or diminishes the power of reacting to the influences which tend to restrain sane persons from breaking the law, so that to punish the insane criminal is useless from the point of view of deterrence ; and it arises in part from the feeling expressed in the old dictum that the madman is sufficiently punished by his madness. The community recognizes that the insane are potentially criminal in a way and to a degree that the sane are not, and it accordingly protects itself against them in anticipation by depriving them of their liberty ; as the counterpart of this denial of the privileges of the ordinary citizen, it exempts them from the responsibilities which accompany these privileges, and, when they commit crimes by reason of their insanity, it excuses them from punishment.

The object of legal tests of responsibility in cases of alleged insanity is, or should be, to give exact expression to these general principles, and to limit immunity from punishment to those offenders whose criminal acts may be reasonably attributed to a condition of mental disease such as would remove or seriously impede the operation of the restraining influences which govern conduct in the ordinary sane individual. It is in regard to the measure in which they realize this ideal and satisfy the humane feelings of the community without endangering its security, that legal tests of responsibility become the proper matter of criticism from the psychiatric point of view. The question whether, and, if at all, under what limiting conditions, insane offenders should be excused from punishment, does not, as such, fall within the province of medical science ; it is a question solely for the community. But, when the views and intentions of the community are clearly known, and when the law purports to give effect to these intentions by formulating tests of responsibility which, in fact, fail of their purpose

because they are based on a misconception of the nature of the morbid phenomena they deal with, then it becomes the business of psychiatry to point out their inadequacy.

And similarly, since in this matter procedure is no less important than principle, when the law lays down the methods by which expert evidence regarding the mental condition of an accused person is to be brought before the court, and when these methods are not adapted to attain their ostensible end, because they prevent the presentation of the relevant facts with the fullness and the connection which are necessary to justify the witness's opinion, then, again, there is legitimate occasion for psychiatric criticism. And on these two aspects of the question, such criticism may be profitable to the law, not only in the interest of the insane offender, but also in the higher interest of social security; the more the law is in consonance with scientific knowledge, and the more fully and clearly the expert evidence on the point at issue is submitted to the common sense of the jury, the more likely is the result to be, and to be recognized as being, in accordance with the real merits of the case.

It is from this point of view that we shall now proceed to examine the doctrine and practice of the law in this country in regard to offenders alleged to be of unsound mind. In the first instance we shall consider the law as actually in force, examining later on the modifications proposed in the recent report of the Atkin Committee.

As we have seen, the law of England, as expressed in the M'Naughten rules, makes irresponsibility on the ground of mental disease depend on proof (i) that such disease existed at the time of the alleged act, and (ii) that it was attended with certain results, viz., that it prevented the insane offender from knowing the nature and quality of the act or from knowing that it was wrong.

In practice, attention is directed mainly to the second of these points; and it may be remarked incidentally that it is an ordinary and almost inevitable consequence of the adoption of such an analytical test that the primary question of the existence of mental disease is apt to be obscured by the secondary question whether the particular disorders specified in the test as resulting from mental disease did or did not exist. This, it may be added, is a point of more than merely academic significance, for not only does the slurring over of the issue of insanity prevent the adequate presentation of medical evidence, but it may also lead to the too ready acceptance, for instance, of allegations of temporary states of confusion without real proof of the presence of conditions that would predispose to the occurrence of such states. This point will be referred to again in connection with the question of expert evidence.

To return, then, to the consideration of the particular conditions resulting from mental disease which must be present to exempt an insane offender from punishment, it will at once be perceived, as was emphasized in the preceding chapter, that the legal criterion of irresponsibility is disorder of intellect, and disorder of intellect alone; the lunatic who has committed a crime is punishable unless his insanity was such as to prevent him from *knowing* what he was doing. If "knowing" is taken, as it most assuredly is taken by juries who have been directed in the terms of the McNaughten rules, in the plain and ordinary sense of the word, and not according to the super-subtle interpretation of Sir J. Stephen, then it is perfectly clear that the test takes account only of the state of the cognitive and perceptive activities of the mind.

The effect of this limitation is that the law imputes responsibility to a very great number of insane offenders

whose punishment cannot serve the interest and would be most repugnant to the feeling and intention of the community. The legal test fails, therefore, to achieve its purpose, and the source of its failure is that it is founded on an erroneous conception of the working of the diseased mind. Its radical fallacy is in its implied assumption that, in conditions of mental disorder, morbid conduct is the outcome of morbid thought—an assumption which, as we have repeatedly seen in our survey of crime in relation to the various forms of insanity, is in complete contradiction with clinical fact. Commonly, if not constantly, morbid impulse is the earliest, and may for a time be the only obvious manifestation of developing disorder of mind.

If we take, for example, the homicidal crimes which are so frequently related to the insanity of nursing mothers, we find, as we saw in Chapter VI, that in the majority of such cases homicidal and suicidal impulses are amongst the first symptoms of disease, and will very often issue in criminal acts with lucid consciousness and full knowledge of the nature and quality of the acts, and without any accompanying disorder of thought. And the same precocity and independence of morbid impulse is a common feature of other forms of disease, as, notably, in general paralysis, in alcoholism, in dementia præcox. In a very large proportion of the instances of murder related to these forms of insanity, a strict application of the authoritative test of responsibility would send the insane murderers to the gallows. The fact that they escape this fate is due simply to the setting aside of the test in practice, and is thus in itself a proof that the test is faulty and does not adequately express the will and intention of the community. It is difficult to conceive that a legal formula of this kind can be a very useful guarantee of public security ; on the contrary, being so much

at variance with scientific knowledge and with public sentiment that its constant violation must be either openly condoned or veiled by giving a non-natural meaning to its terms, it can only weaken the authority and detract from the dignity of the law by investing it with an appearance of excessive but impotent severity.

If, then, it be admitted that the existing criterion of irresponsibility is plainly inadequate to its purpose, and that it should be either modified, or entirely discarded and replaced by a more appropriate test, the question arises as to which of these two methods of reform is to be preferred. The Atkin Committee, which may presumably be taken to voice legal opinion on the matter, advocates the method of modification. It would maintain the McNaughten rules in their integrity, but would add to them an explicit recognition of the irresponsibility of an insane offender when he commits the act imputed to him under irresistible impulse. This alteration would unquestionably remove one of the most serious grounds of objection to the present legal test, and would get rid to a great extent of the glaring contradiction which now exists between the theory and the practice of the law.

But it is somewhat difficult to see what advantage it presents over the more radical reform by entire recasting of the legal formula—unless, of course, it be considered an advantage to maintain the McNaughten phraseology out of regard for antiquarian sentiment. And there are substantial reasons against this conservative method. The McNaughten rules are founded on a system of ideas which, however erroneous it may be, is, at all events, in itself logical and coherent, and the admission of the doctrine of irresistible impulse is entirely inconsistent with its spirit. To repair this worn-out but respectable formula by putting on a patch from a totally different pattern of thought, is not likely to produce a very har-

monious effect. And, apart from the incongruity which would result from this way of amending the test, the maintenance of the McNaughten rules, even with the proposed addition, is objectionable on other grounds. It would involve, for instance, the retention of the rule that, in cases of delusional insanity, the content of the delusion is the criterion of responsibility—that the lunatic who murders his supposed persecutor is exempt from punishment if he believed at the time that his victim was about to kill him, but is punishable if his delusion is merely that his fancied enemy was reading his thoughts or tampering with his genital organs. This curious product of legal psychology belongs quite naturally to the order of ideas which inspired the McNaughten rules, but it is clearly out of place in a modern definition of the conditions of responsibility.

If, on these considerations, it appears desirable that the McNaughten formula should be entirely abandoned, and replaced by a fresh statement of the law, interpreting more accurately the will of the community, then the next question that arises is as to the general principle on which the new statement should be framed—should it simply recognize insanity as being in itself a bar to responsibility, leaving to the jury to determine, as a question of fact, whether in the particular case the accused person was or was not insane and irresponsible at the time of the act, or should it demand proof, as a condition of irresponsibility, not only that the accused person was insane, but also that his insanity had influenced his conduct in one or more of a number of specified ways? The practice of foreign countries provides instances of both these methods of dealing with the question. Thus the French Code makes irresponsibility coextensive with insanity: “There is neither crime nor misdemeanour (*délit*) when the accused person was in a state of madness (*démence*) at the time

of the act." The German Imperial Code, on the other hand, uses a formula similar to the English test, but expressed in rather more concise terms : "There is no punishable act if the doer of the act was at the time in a state of unconsciousness, or pathological disorder of mental activity (*krankhafte Störung der Geistesthätigkeit*) by which his free exercise of will (*freie Willungsbestimmung*) was excluded."

The relative merits of these two legal formulæ cannot be fully estimated without taking account of the methods of procedure by which they are respectively applied ; but it may, nevertheless, be worth while, before referring to their practical operation, to consider these opposed principles from a general point of view. The arguments against the apparently more lax system of French law are set out in the report of the Atkin Committee in connection with the proposal that a somewhat similar system should be adopted in this country. The main ground of objection taken in the report is that the limits of insanity are too vaguely defined, and its diagnosis is too difficult, to allow of its being made an excuse from punishment without weakening the administration of the law and endangering public security : "If an offender tends to escape punishment by reason of nicely balanced doubts upon a diagnosis of uncertain mental conditions, the observance of the law is gravely hindered."

But this objection, though it has a certain plausibility, does not appear, when examined more closely, to be of much substance. In the first place, the doubts and uncertainties which the report indicates are not removed when the issue is shifted from the question of insanity to the question of capacity to know the nature and quality of an act or to resist an impulse. In instances where there are real elements of doubt and uncertainty, these elements have their source in the nature of the case ;

and in such instances it is just as hard for the conscientious expert to offer an opinion, and for the jury to decide what value it should attach to that opinion, whether the question be as to the sanity or insanity of the accused, or as to his insight into his conduct or his ability to control his actions.

The difficulty may, indeed, be greater when the issue is put in the latter form, for the multiple and convergent facts of observation on which the expert bases his diagnosis are obviously more within his power of appreciation and more familiar to his ordinary ways of thought than are speculations about the subjective aspects of a particular insane act. His opinion, therefore, is likely to be more assured, and the arguments by which he supports it will be more accessible to the critical scrutiny of the common sense of the jury, when he is dealing with matters within his competence than when he is theorizing about matters which are hardly within the competence of any man. The alienist has constantly to decide in the ordinary exercise of his profession whether he can certify a patient as insane, and what facts he is to put in his certificate which will justify his opinion, but he is venturing into strange and uncharted waters when he presumes to follow the workings of the diseased mind in regard to such subtle points as are involved in analytical tests of responsibility.

To these considerations it may, of course, be objected that even in such tests the existence or non-existence of insanity is the primary issue which the expert and the jury have to deal with, and that the questions of insight and power of control only arise on the assumption that insanity has been proved. That is so, no doubt, in theory, but in actual practice, as has been already remarked, and as is abundantly shown by the record of cases where the issue of responsibility has been keenly disputed, it is to

these secondary points, and not to the question of the prisoner's sanity, that attention is mainly directed. This appears, indeed, to be recognized by the Atkin Committee, when they deprecate the attitude of judges, who, "anxious to save time, bring the witness to the decisive questions," without allowing him to develop fully his reasons for holding the prisoner to be of unsound mind. The fact that such an implied criticism is called for, and from such a source, indicates the inevitable tendency, in these analytical tests, for the secondary question as to knowledge of the nature and quality of the act, to replace altogether what should be the antecedent question of the sanity or insanity of the accused person. And naturally so, for, however it may be in theory, these two divisions of the legal test will, in practice, almost inevitably be treated as independent and equivalent; and, as the real point at issue is the question of responsibility, it is on the specific conditions determining that question that attention will be concentrated: the prisoner's insanity, apart from his responsibility, will not be considered at all. It is highly improbable, for instance, that a jury, convinced that a prisoner is insane, will find him guilty on the ground that, despite his insanity, he may have known what he was doing.

Except, therefore, in so far as it tends to obscure or shut out the issue of insanity, the insistence by the law on its special criteria of irresponsibility is little likely to achieve its presumed purpose of preventing the undue extension of the grounds of immunity from punishment. And it is quite conceivable that it may have just the contrary effect, for there is an obvious risk that the minds of the jury may be confused, and their critical judgment of the value and significance of the expert evidence may be impeded, when the stress of inquiry is transferred to such subtle issues as the exact degree of capacity possessed

by the accused person to estimate the legal value, or the moral value, of his act, or to discriminate between its legal and moral values, or to control the impulses prompting to it. It might well happen that, in the metaphysical fog generated by the discussion of these involved questions, an astute and callous assassin should occasionally escape the due penalty of his misdeeds, much more easily than if he had to give clear and definite proof that he was insane. False statements, which the prisoner may have made at one time or another, can be much more plausibly put forward as delusions, tending to explain and justify the criminal act, when they are dealt with as more or less isolated facts, than would be the case if the expert for the defence had to show that they possessed the characters of insane delusions and were consistent with the other symptoms presented by the alleged lunatic.

On the whole, then, it would seem that, as compared with the simple formula of the French Code, the analytical test of responsibility gives no greater measure of social protection, and may possibly give less. Of course, whatever sort of test is used, there will be difficult and doubtful cases, but the doubts and difficulties in such cases are inherent in the facts, and cannot be got rid of by any trick of legal ingenuity. For practical purposes they will be best resolved by the untrammelled exercise of the common sense of the jury, which will be least likely to be at fault when it is applied to the single definite issue of the prisoner's mental condition.

As against this view, there is, in fact, only the theoretical objection that insanity does not admit of exact definition, and as we have seen, it is on this objection that the Atkin Committee mainly base their preference for the analytical type of test. It hardly seems, however, that any great weight can be attached to this argument, in view of the fact that the law elsewhere admits that

insanity *per se* and without any limiting conditions can be a sufficient ground for exempting from capital punishment. In the relevant section (*vide* Appendix) of the Criminal Lunatics Act, 1884, which prescribes the procedure in the case of a prisoner under sentence of death, when the Secretary of State has reason to believe that such prisoner is insane, the statute uses throughout the words "insane" and "insanity" without definition or qualification of any sort: the medical practitioners appointed to examine the prisoner are directed to "inquire as to his insanity," and "may certify in writing that he is insane." That is to say, as is pointed out by the Atkin Committee, who fully endorse these provisions of the law, the statutory inquiry deals merely with "the prisoner's sanity or insanity, i.e., his condition from a medical point of view"; the experts who conduct the inquiry have not to consider whether, if he be insane, he is also irresponsible according to the legal test, that he did not know the nature and quality of his act. So that it is quite conceivable, and does in fact happen, that an insane murderer, who has been condemned at his trial as being responsible according to law, though he may have been proved insane, will nevertheless be exempted from punishment at a later stage on the score of his insanity alone. In effect, then, this is an abandonment by the law of the analytical test, and an acceptance of the simpler formula which declares that insanity should imply irresponsibility.

It is somewhat difficult to see what is gained by the adoption of this inconsistent attitude. In its ultimate results, the maintenance of the M'Naughten test with the safety-valve of the statutory inquiry, would appear to differ from the initial acceptance of the simpler test, only in two material particulars—(i) it withholds from the critical consideration of the jury and the public the

medical evidence on which the issue is finally decided ; and (ii) it refers the question of the prisoner's mental state to the judgment of impartial experts, instead of making it the matter of controversy in court, based on the opposing views of *ex-parte* medical witnesses as to whose respective credentials and authority the jury is necessarily ill-informed. The first of these results is obviously to be deprecated, and the second, which is no less obviously to be desired, can, of course, be ensured quite readily in connection with any sort of test, and is not, therefore, to be regarded as an argument in favour of the retention of the present clumsy and illogical system.

The point touched on in the last paragraph brings us to the consideration of a question which has probably much more real importance than attaches to the form and wording of legal tests of responsibility, the question, namely, of the mode of presentation of expert evidence in cases of alleged insanity.

If it be admitted that, in this connection, the governing purpose of the law is to prevent such extension of the grounds of irresponsibility as may be a menace to society ; and if, as we have seen to be the case, this purpose cannot be achieved, without violence to public sentiment, by exact legal definition of the particular effects of mental unsoundness which shall excuse from punishment, then the necessary safeguards against the abuse of the plea of insanity must be sought in a stringent standard of proof for the establishment of that plea. The punishment of an undoubted madman does not serve the interest, and can only very rarely gratify the feeling of the community ; and when public opinion is stirred to resentment at what it regards as undue leniency to a criminal on the ground of his alleged unsoundness of mind, it is almost always because it is sceptical as to the

genuineness of his insanity. And the source of this scepticism is mainly to be found in the unsatisfactory way in which the evidence on this point is brought out.

The jury, and the public whom the jury represent, know that the limits of insanity are vague and uncertain, that doctors differ, that expert witnesses have inevitably some degree of bias to the side by which they are retained. All these considerations must affect their judgment when they have to make up their minds about a prisoner's responsibility from the evidence of *ex-parte* witnesses, of whose expert knowledge there is no guarantee, and who may entertain, and may have been selected because they are known to entertain, unusual and strictly personal views about insanity. It is not surprising if, in these circumstances, medical testimony in support of the plea of insanity is regarded by judges and jurymen with a certain amount of suspicion. In a great measure this suspicion would be removed if the evidence on this issue was given by impartial witnesses, chosen by the court on the score of their acknowledged standing and experience, and permitted to present their conclusions, and the grounds on which they have formed them, as a full and connected statement, and not in the artificial and fragmentary form of replies to a series of more or less relevant questions, which at best can only cover a part of the facts. This is, in substance, the method adopted in countries where mental disease is recognized as involving immunity from punishment; it is, indeed, a necessary accompaniment of this unqualified test of responsibility, and affords probably the most effective guarantee against the abuse of the plea of insanity.

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It is easy to see how the system would work by imagining its application to some of the cases of morbid crime discussed in the clinical section of this book. Take, for instance, the paralytic murderer of Obs. 2, p. 34. This,

it will be recalled, was a case of apparently premeditated murder with a view to robbery, a crime which, *prima facie*, would not suggest an insane origin. Had a plea of insanity been raised at the trial, and had it been supported only by the evidence of medical witnesses called for the defence, could the jury be expected to accept the view that certain abnormalities in the prisoner's reflexes and certain alterations in his cerebro-spinal fluid, were sufficient to prove the existence of gross disease of the brain, to which his criminal conduct could be reasonably attributed? And, even if the jury were prepared to believe the *ex-parte* evidence that these conditions were really present, could they do otherwise than convict the prisoner, if the issue put to them, and the questions addressed to the medical witnesses, were in the strict legal form as to the murderer's knowledge of the nature and quality of the act, and his power to resist the impulse which led to it? On the other hand, a full report from an expert, whose competence and impartiality would be guaranteed by his official standing, would have established at the outset of the case the fact of the prisoner's insanity and the relation of the crime to his mental disorder.

Similarly in Obs. 14, p. 81, where a man suffering from delusions of jealousy raped and murdered his child, the insanity of the murderer, and the community of morbid origin of his delusions and of his criminal act, despite their logical independence, would have readily been made out to the satisfaction of the jury by the evidence of an official expert, presented in connected form and necessary detail, and untrammelled by the restrictions of legal tests of responsibility; whereas the actual method of oral testimony by *ex-parte* witnesses in reply to questions directed solely to the prisoner's intellectual disorder, could obviously provide only a very blurred

and unconvincing view of the facts. In each of these cases, the capital sentence was set aside after a statutory inquiry ; but it would clearly have been preferable, from every point of view, if this result had been reached at the outset, and not by the tedious stages of trial, appeal, and revision by the Secretary of State.

Of course, even with the more rational system here suggested, there will remain doubtful and difficult cases, cases where the offenders are on the borderline between sanity and insanity, so that, while they can hardly be regarded as fully accountable, yet their entire exemption from legal punishment would probably be against the interest, as it would most certainly be against the sentiment of the community. In regard to this point, the zeal of some mental specialists has occasionally left them open to the just criticism of the lawyers. The fact that the limits of insanity are necessarily vague and ill-defined does not justify their expansion to include every kind and degree of mental abnormality. Deviations from the average in character and disposition, which are common enough both in criminals and in law-abiding persons, but which in themselves do not involve any incapacity to enjoy the privileges of the ordinary citizen, can hardly be held to confer immunity from the penalties attaching to the abuse of these privileges. There is no sufficient ground for assuming that all abnormal persons are so insusceptible to the deterrent influence of punishment that the fear of it has no effect in restraining them from the pursuit of their selfish ends by illegitimate means. They are, no doubt, less amenable to this influence than are persons better endowed constitutionally ; but, unless their abnormality is considerable, they are amenable in some measure, and it would, therefore, be clearly inexpedient for society to renounce altogether in their regard its ordinary means of self-defence.

It is, of course, to be understood that there is no reference here to imperfectly developed conditions of insanity: it would obviously be incorrect, and in contradiction with all clinical experience, to suppose that in the initial stages of real mental derangement the sufferer's ability to resist his morbid impulses is any greater, and it may quite conceivably be less, than when the diseased state is more fully declared. A pathological process, whatever be its stage of development, is in a different category from a trivial abnormality of character, and the relaxation of the rigour of the law which may be proper in the former case is not necessarily applicable to the latter.

But, though an entire immunity from punishment cannot safely be allowed to offenders of this borderline class, nevertheless the general sense of equity may approve of some recognition of the handicap which they suffer by reason of their constitutional defect. And this recognition may be most appropriately accorded by the admission of the principle of diminished responsibility—in the language of Professor Grasset, by treating the *demi-fou* as *demi-responsable*. This principle has not hitherto found much favour in England, though something approaching it has been implicitly accepted by the law within recent years, as, for instance, in the view that drunkenness may, in certain circumstances, reduce the gravity of a homicidal act from murder to manslaughter. It has, however, been definitely adopted in the legal codes of some other countries. Thus, for example, in the Italian Penal Code of 1889, the effect of mental disorder on criminal responsibility is defined in the following terms: “Article 46.—No one is punishable who, at the time of doing the act, was in such a state of infirmity of mind as to deprive him of the consciousness of his acts, or of his freedom of action. Article

47.—If the state of mind indicated in the preceding article was such as greatly to diminish responsibility, without, however, excluding it, the punishment prescribed for the crime committed is to be reduced.” And the same principle is affirmed in substantially similar terms in the latest draft revision of the Imperial Criminal Code in Germany.

To give practical effect to this provision, it is suggested that, in cases of diminished responsibility, the offender shall be liable to such punishment as would attach to conviction for a minor degree of the same crime—if the crime, for instance, were murder, the punishment would be that prescribed for attempting or being an accessory to murder. And it is further proposed that, when judged necessary in the interests of public security, the offender, after completing his mitigated sentence of imprisonment in a penal institution, may be detained indefinitely under asylum conditions. Whether developed on these or on other lines, a system embodying this principle would appear to be the most suitable means of meeting the very real difficulty which is presented by the class of morbid offenders who cannot be regarded as entirely irresponsible without risk of weakening the defences of society, but who, at the same time, cannot be held fully accountable for their crimes without some violence to public feeling.

The conclusion, then, to which we are led by the critical examination of this question from the point of view of psychiatry, is that the existing state of the law and procedure regarding criminal responsibility in cases of alleged insanity, corresponds neither to the interest nor to the sentiment of the community : by the maintenance, in theory, of a test of responsibility which cannot be enforced in practice, the law affords only an illusory protection to society ; it adopts an attitude of excessive

harshness, and, to avoid the consequences of that attitude, has to condone evasions and resort to devices which may have the effect of undue leniency; its methods for obtaining and presenting expert evidence on the issue of insanity are at once too lax and too restrictive; and the general tendency of its operation is to impose undue limitations on the freedom of the jury, and to impair the authority of their verdict.

These evils would be removed, at all events in some measure, by the adoption of a simpler test of responsibility; by the admission of a qualified responsibility in cases where the offenders, though not certifiably insane, are abnormal to a pronounced degree; and, finally, but of greatest importance, by the establishment of a system for providing the court with full, impartial and authoritative expert evidence as to the mental state of the accused person. With these modifications of the law, the question of the offender's responsibility might be left to the decision of the jury, without serious risk of prejudice to the interests either of the community or of the prisoner. If any additional safeguard were needed, it should be sufficiently provided by a second independent expert inquiry for report to the Court of Criminal Appeal. In this way, the supreme authority of the law would be maintained, and the impartiality and publicity essential to the administration of justice would be ensured.

APPENDIX

LEGAL PROCEDURE IN CRIMINAL CASES INVOLVING THE ISSUE OF INSANITY

In the case of non-indictable offences, and of such indictable offences as are triable summarily, the question of the mental state of the accused person does not normally arise. The courts of summary jurisdiction, which deal with these minor offences, may, however, when there is reason to suspect that the defendant is of unsound mind, remand him for medical examination, and, if he is reported to be insane, usually hand him over to the Poor Law authority or to the care of his friends.

These courts, as courts of first instance, have to do also with indictable crimes, but only to the extent of ascertaining whether a *prima facie* case has been made out against the person charged, who, in that event, is committed for trial at sessions or assizes; the sanity or insanity of the defendant does not come under consideration at this preliminary inquiry. Nor does it arise in the investigation by the coroner of cases of violent death: the coroner's jury in such cases may by their verdict impute culpability to some person, but they are not authorized to inquire or to express an opinion as to his mental condition.

The first stage of the proceedings at sessions and assize courts is the examination of the charge by the grand jury, who, if they are satisfied that there is sufficient evidence to send the accused party before a petty jury, find a true bill against him. The grand jury are not concerned with the question of the defendant's mental state. This question first arises when the defendant is arraigned, when it may be intimated to the Court, either by the prosecution or by the defence, that he is unfit to plead to the indictment. A jury is then empanelled to try this particular issue. The

law does not impose any rigid test of fitness to plead, but leaves it to the judge and jury to decide the question on medical evidence as to the prisoner's capacity to understand the charge against him, to distinguish between the pleas of guilty and not guilty, to challenge jurors, to instruct counsel, and so forth. If the jury find that the defendant is insane on arraignment so as to be unfit to plead, the Court orders him to be detained as a criminal lunatic during His Majesty's pleasure. If, on the other hand, they find that he is fit to plead, he is called upon to do so, and, if he then pleads guilty, it would appear that, in strict law, he must be sentenced forthwith, and no question of his mental condition at the time of the alleged act can be raised.

Under such circumstances, a somewhat embarrassing situation may arise, for a person who is undoubtedly of unsound mind, but is of sufficiently lucid intelligence to convince the jury that he is quite capable of understanding the proceedings, and who is accordingly found fit to plead, may plead guilty from insane motives—in order to get hanged, or to prevent inquiry as to his sanity. To avoid this difficulty, medical witnesses sometimes take a rather extreme view of what should constitute unfitness to plead, and hold that such fitness is excluded by the very fact of insanity. In practice, however, this view may lead to serious inconvenience, as it involves the detention as a criminal lunatic of a person who has not been found to have committed any criminal act, and who may be quite capable of appreciating the injustice of such treatment.

It would, therefore, appear decidedly preferable to adopt a less exacting standard, and to admit fitness to plead in all cases where the defendant is not clearly incapable of being mentally present at his trial. The possibility of a miscarriage of justice arising from the subsequent attitude of the prisoner could easily be prevented by giving judges the power, which many of them in such circumstances already assume, of refusing to accept the plea of guilty when there is a doubt as to the sanity of the accused person.

When the prisoner has been found fit to plead, or when no question of his fitness has been raised, and he pleads not guilty, he may set up the defence of insanity at the time of the alleged crime. While the question of fitness to plead, which relates only to the mental condition of the defendant,

at the time of arraignment, is decided, as we have seen, without reference to any rigid formula, the defence of insanity at the time of the crime is limited, at least in theory, by the legal test founded on the McNaughten rules, and quoted in Chapter XIV. If this defence is established to the satisfaction of the jury, they return the special verdict under the Trial of Lunatics Act, 1883, to the effect that the accused "is guilty of the act or omission charged against him, but was insane, so as not to be responsible, according to the law, for his actions, at the time when the act was done or the omission made." When such a verdict has been returned, the prisoner is ordered by the Court to be detained as a criminal lunatic during His Majesty's pleasure. There is no appeal against this verdict, or against the verdict of "insane on arraignment." But a prisoner who has been convicted, whether at his trial he pleaded insanity and failed, or did not raise that defence at all, may appeal against his conviction on the ground of insanity, and the Court of Criminal Appeal may quash the conviction and may substitute a verdict of "guilty but insane."

In capital cases there may be further inquiry into a prisoner's sanity after his conviction, and, if he appeals, after the rejection of his appeal. The procedure in such cases is laid down in section 2, subsection (4), of the Criminal Lunatics Act, 1884, which reads: "In the case of a prisoner under sentence of death, if it appears to a Secretary of State, either by means of a certificate signed by two members of the visiting committee of the prison in which such prisoner is confined, or by any other means, that there is reason to believe such prisoner to be insane, the Secretary of State shall appoint two or more legally qualified medical practitioners, and the said medical practitioners shall forthwith examine such prisoner and inquire as to his insanity, and after such examination such practitioners shall make a report in writing to the Secretary of State as to the sanity of the prisoner, and they, or the majority of them, may certify in writing that he is insane." Subsection (1) of the same section of the Act empowers the Secretary of State, if he thinks fit, to direct the removal to an asylum of any prisoner, whether under sentence of death or of imprisonment, who has been certified insane in the manner provided in the Act.

In criminal cases, where the alleged mental disability of the offender is attributable to original deficiency, as distinct from insanity, important modifications have been made in the law and procedure by the Mental Deficiency Act, 1913. Prior to the passing of that Act, a mentally defective person charged with a criminal offence could not be dealt with otherwise than under the ordinary practice of the courts in respect to the plea of insanity—that is to say, if the offender's defect of mind was such as to render him insane so as not to be responsible according to law at the time he committed the act imputed to him, the jury could find him "guilty but insane," and he would then be detained as a criminal lunatic. If his mental deficiency fell short of that degree, he was held liable to ordinary punishment. And it was in fact laid down explicitly in several judicial decisions that mere mental deficiency did not entitle a jury to return the special verdict under the Trial of Lunatics Act.

The Mental Deficiency Act altered this position materially. Under section 8 of that Act it is provided that on conviction by a court of competent jurisdiction of any person of any criminal offence punishable in the case of an adult by penal servitude or imprisonment, the Court, if satisfied that such prisoner is defective, may, in lieu of passing sentence of imprisonment or other punishment, send the defective offender to an institution for defectives, or may place him under guardianship, or may, remit the case to a judicial authority to be so dealt with under the Act. And the section further provides that the same procedure may be followed in the case of children who are liable, under the Children's Act, 1908, to committal to a certified industrial school, and also in the case of persons found to be amenable to the Inebriates Acts. It should be specially noted that the Mental Deficiency Act does not apply to persons charged with capital offences—that is to say, with murder or treason. Defectives indicted for these crimes come under the ordinary law.

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